Submission for the Five Year Review of Auto Insurance

Ontario Psychological Association

July 14, 2008
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Executive Summary

Overview
This submission will address the Ontario Psychological Association’s ideas on how to ensure a robust and effective auto insurance system that meets patient needs for restoration of health and functioning while at the same time controlling costs and maintaining affordability. In doing so, we are also mindful of the larger picture of the interconnectedness of the auto insurance system and the public health and welfare systems.

Structure of this submission
Bob Christie, Chief Executive Officer and Superintendent of Financial Services announced on June 3, 2008, the Ontario Auto Insurance Five Year Review. In our submission, we address each of the terms presented by Mr. Christie, starting with affordability, availability, and consumer protection concerns. In each section, we provide recommendations for possible changes to the SABS and dispute resolution processes that we believe will improve affordability, availability of rehab benefits, and consumer protection. The review also invites us to examine other issues of concern, and we do so at the end of our document.

In an attempt to identify issues and concerns more fully, and to provide suggestions, we conducted a survey of psychologists engaged in all aspects of service delivery in the auto insurance system. We use data from this survey throughout our submission to speak to the issues of cost controls, consumer protection, specific SABS provisions, dispute resolution, and other issues, as identified in the terms of reference for the Review.

Putting patients first
We believe that the key to maintaining affordability, availability of benefits, and consumer protection is remembering to always put patient needs first. In this way, treatment and rehabilitation efforts are maximized and accident benefit dollars are spent effectively to produce the desired result. We suggest that maintaining a focus on patient needs first will also help to inform any potential changes to the SABS or dispute resolution processes, so that the needs of the auto system and the larger public system for cost control are both served by maximizing access to timely, effective intervention.

Our Recommendations
In our submission, we provide detailed recommendations for addressing the issues and concerns suggested by Mr. Christie for this review. The following are highlights of these recommendations:

1. Encourage earlier referrals to psychologists;
2. Use WSIB screener for psychological factors to facilitate early identification and referral to psychologists;
3. Require copies of OCF-22s and 18s be sent to patients when they are submitted to the insurer;
4. Separate types of “assessments” in any future data to be collected, so that stakeholders are able to determine which type of assessments are truly driving costs;
5. Do not impose caps on OCF-22s;
6. Require that a health professional of the same discipline as the proposed assessment completes the OCF-22;
7. Require that the health professional gather information from the patient to be assessed in order to complete the OCF-22;
8. Require documentation of this contact, and a signature from the health professional proposing the assessment;
9. Require that simultaneous OCF-22s from the same facility be combined into a single, multi-purpose application;
10. Require that the various health professional disciplines in a multi-disciplinary application each have documented contact with the patient in order to obtain information required to complete the application;
11. Require confirmation of patient contact for the OCF-22 with signature of each health discipline;
12. Require adjusters to call proposers of assessment and treatment plan proposals when there are concerns, and make this a billable activity;
13. Require adjusters to include a rationale when not approving an assessment or treatment plan proposal;
14. Consider extending insurer time for consideration of assessment and treatment plan proposals, if rationales and time for communication with proposers are required, as recommended;
15. Require that Insurer Examiners experience working within the MVA sector;
16. Require that Insurer Examiners are from the same health discipline as the proposer of the assessment or treatment plan before referral for review;
17. Require Insurer Examiners to indicate that they have a clinical/consultation treatment practice in the area that they are asked to review for both assessment and treatment plan proposals;
18. Require Insurer Examiners to call proposers of assessment and treatment plan proposals when there are concerns, and make this a billable activity;
19. Improve dispute resolution processes after the IE decision;
20. Require insurers to consider and respond to rebuttal reports and provide rationale if denial is maintained;
21. Develop a “Fast Track” mechanism for dispute resolution;
22. Include a “help line” or other support for claimants;
23. Encourage all health professionals (proposers and reviewers) to use existing guidelines and standards for practice;
24. Encourage adjusters to familiarize themselves with profession specific guidelines for assessment and treatment such as the OPA Guidelines for assessment and treatment in auto insurance claims;
25. Partnerships of colleges and health professional associations to provide ongoing multidisciplinary educational opportunities regarding rehabilitation of motor vehicle injuries;
26. Develop a mechanism for use of the UDAPs and include information on the FSCO website;
27. Encourage colleges and health professional associations to partner with existing organizations, such as the Canadian Health Care Anti-Fraud Association to reduce fraud within the auto sector;
28. Consistent with our scope of practice, include psychologists in the regulations to adduce evidence for psychological and mental impairments;
29. Ensure that psychological impairments are not discriminated against and are included equally in whole person impairment ratings for catastrophic determination;
30. Resume regular multidisciplinary stakeholder consultations on an ongoing basis, so that communication is maintained, data are shared, and concerns about issues are resolved more effectively.
31. Re-activate HCAI with appropriate modifications to be discussed in stakeholder consultations. We believe that this will be a significant contribution to collecting sound, accessible data on the functioning of the auto insurance system. We also see this as a step toward using electronic processes to reduce transaction costs.

In addition, we also encourage adoption of the recommendations made by the Coalition Representing Health Professionals in Automobile Insurance Reform in their submission.
Introduction

Consumer protection, restoration of health and function, AND cost control for product affordability

It is contrary to our social contract to jeopardize the health of Ontario citizens to accomplish cost controls. At the same time, we must have affordable auto insurance. There are a number of measures available which would increase claimant, health professional, and insurer accountability and provide cost savings without creating unreasonable barriers to injured accident victims seeking the benefits necessary to restore their health. When examining stakeholder proposals for cost savings, consideration must be given to potential unintended negative consequences of poor health outcomes and increased disability. Further, implementation of some suggestions for cost savings might ultimately increase costs to auto insurers and also create more immediate burdens on the public health and welfare systems for treatment and rehabilitation and costs.

When patient needs are met within the auto insurance Accident Benefit (AB) system, the needs of the larger public health and welfare system are also met. Productivity and efficiency are maintained by rehabilitating patients and restoring function as a whole person after an MVA. An auto insurance system that focuses on cost control at the expense of meeting patient needs sends unaddressed healthcare problems to the already over-burdened public system.

We are committed to ensuring that the AB system functions to address the needs of injured people so that they return to active, productive lives. Although this is the mandate of treatment and rehabilitation benefits under the auto insurance system, it is not always effective in achieving this goal. It is our hope that changes to the auto insurance product will make it more effective and efficient in meeting patient needs. In this way, consumers of auto insurance will be protected, patient needs will be addressed, and costs will be minimized for both the auto insurance sector and the larger public health and welfare systems.

Maintaining affordability and availability of auto insurance is an important goal of the government and our association. One approach to achieve this is improving the quality of benefit applications and reducing those that are fraudulent, wasteful, and do not serve the restorative purposes of the SABS. However, affordability and reduction of wasteful services must be coupled with an emphasis on consumer protection and ensuring that cost controls do not interfere with achieving the fundamental goal of the auto insurance accident benefits system: to provide compensation and services to restore health and personal, social and vocational function to those injured and traumatized in accidents. Mechanisms to address inappropriate or excessive behaviours of a tiny minority of participants in this system must not interfere with achieving this important goal of restoring health and function for the majority of Ontario citizens affected by MVAs.

This submission will address the Ontario Psychological Association’s ideas on how to maintain a healthy and effective auto insurance system that addresses the needs of the
whole person and avoids offloading costly problems to the larger public health system. In doing so, we will address issues of affordability and accessibility of benefits for injured people, consumer protection, and cost efficiency.

Before we address these pressing matters, we remind readers of what psychologists do, who we are, and how we function within the larger health system.

**Role of psychologists**
The Ontario Psychological Association is the professional association representing registered psychologists in the province of Ontario. It has 1400 members. Approximately 200 provide psychological assessment to patients with auto accident injuries. In 1989, the OPA formed an Auto Insurance Task Force, which has been continuously involved since that time in advocating for access of patients with psychological impairments to psychological services.

Psychologists play an important role in Ontario’s health care system. Psychological factors are central to the health and health problems of Canadians. Consequently, it is essential that psychological factors are acknowledged and addressed, and are done so by the professionals in our society that are best able to assess and treat them.

**Authorized acts and scope of practice:**
Psychologists are uniquely qualified among the regulated health professions in Ontario to assess and diagnose mental, emotional, cognitive, and behavioural impairments.

Current legislation describes the practice of psychology as, “the assessment of behavioural and mental conditions; the diagnosis of neuropsychological disorders and dysfunctions; the diagnosis of psychotic, neurotic and personality disorders and dysfunctions; the prevention and treatment of behavioural and mental disorders and dysfunctions; and, the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning” (*Psychology Act*, 1991, c. 38, s. 3).

Psychologists are uniquely qualified to diagnose these disorders. As noted in current legislation, “In the course of engaging in the practice of psychology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis identifying, as the cause of a person’s symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder” (*Psychology Act*, 1991, c. 38, s. 4).

The role of members of the College of Psychologists of Ontario in providing diagnosis of impairments and disorders is well established in both accident benefits and tort claims under the *Insurance Act*. The following are illustrative:

The SABS states: “impairment” means a loss or abnormality of a psychological, physiological or anatomical structure or function;
Regulation O. reg 461/96 as amended by O. reg 381/03 provides a “definition of permanent serious impairment of an important physical, mental, or psychological function.”

The SABS also includes psychologists as health practitioners. The SABS states, “health practitioner, in respect of a particular impairment, means… a psychologist, if the impairment is one that a psychologist is authorized by law to treat”.

Thus, the concept of psychological impairment is a core component in the definitions of impairments that qualify for AB applications or the right to sue for non-pecuniary loss and future care.

The development and delivery of effective and efficient treatment depends upon accurate diagnosis of the psychological components of illness and injury. Psychologists are the healthcare professionals best trained to assess, diagnose and treat psychological factors affecting health.

Despite the crucial role of psychologists in treating MVA survivors, psychologists do not see the vast majority of these survivors. In fact, data from FSCO over several years indicates that psychological services historically have represented only a small percent of overall costs (2-4%) of clinical assessment, treatment, and rehabilitation under auto insurance.

Psychologists rarely see those who have been in minor accidents (that is, those in which no medical attention was sought for injuries sustained in the accident). However, we would suggest that we often see the most vulnerable individuals with serious injury and trauma. Our patients are often those who have the most complicated combination of physical and mental impairments, thus making them the most challenging to rehabilitate. They often come to the MVA and the accident benefits system with vulnerabilities that cause them to experience unanticipated difficulties after an MVA. They also can be difficult interpersonally. These are often the very people who are least likely and least able to speak up for themselves, and most likely to be dropped or overlooked by many other health providers. When this happens within the auto sector, our patients and their unmet needs are sent to the public system for management, and the true cost of their impairments is addressed by OHIP and Ontario Works in terms of disability, lost productivity, and greater demands for services over the person’s lifetime.

The scientific literature that is fast growing in this area indicates that the small subgroup patients with co-morbid medical conditions and significant psychological impairments can result in a large drain on any system in which they are subscribers. The data are also clear in indicating that psychological services offset the cost of this drain by reducing impairments and returning people to more productive lives.

A comprehensive psychological assessment can assist in remedying this drain on the system by: identifying those at risk for developing such impairments, conveying this information to others in order to prescribe and direct appropriate interventions, and
serving as an indispensable communication tool in explaining a given patient’s progress in their rehabilitation. Psychologists also provide treatment that prevents and reduces disability, returns patients to work, improves patients’ quality of life, and provides substantial cost savings to payor systems.

Psychology has a unique role to play in putting patient needs first when addressing the whole person and restoring health and functioning. As such, psychologists are also uniquely positioned to ensure cost-effectiveness of rehabilitation provided in the private auto sector, and reduce off-loading to the public health system.

We are pleased to be submitting our ideas for how to improve the auto insurance product so that it meets the needs of all Ontarians better. In our submission, we demonstrate how psychologists can improve the functioning of the auto insurance system, reduce costs to insurers by restoring function, and avoid offloading complicated, difficult client needs to the public system.

**Terms of the Review**

Bob Christie, Chief Executive Officer and Superintendent of Financial Services, announced on June 3, 2008, the Ontario Auto Insurance Five Year Review. The following topics were suggested for comment:

- **Affordability and Availability**
  Improvements to the auto insurance system that maintain affordability and availability for consumers.

- **Consumer Protection**
  Further measures that may enhance consumer protection in purchasing auto insurance and accessing compensation and services following an accident.

- **Statutory Accident Benefits Schedule**
  Possible changes and improvements to the Statutory Accident Benefits Schedule in particular to reduce complexity and enhance compliance.

- **Dispute Resolution at FSCO**
  Possible changes that could improve the Dispute Resolution process at FSCO.

- **Other Issues**
  Any other issue related to auto insurance that improves fairness and can improve the efficiency and operation of the auto insurance system including regulatory burden reduction proposals

We believe that the key to maintaining affordability, availability of benefits, and consumer protection is remembering to always put patient needs first. In this way, treatment and rehabilitation efforts are maximized and accident benefit dollars are spent effectively to produce the desired result. We suggest that maintaining a focus on patient needs first will also help to inform any potential changes to the SABS or dispute resolution processes, so that the needs of the auto system and the larger public system are both served by maximizing access to early, effective intervention.
We address each of the terms presented by Mr. Christie, starting with affordability, availability, and consumer protection concerns. In each section, we provide recommendations for possible changes to the SABS and dispute resolution processes that we believe will improve affordability, availability of treatment and rehabilitation benefits, and consumer protection. Other issues of concern specifically to psychologists are addressed at the end of the document.

**Addressing patient needs: OPA survey data**

In its announcement of the review of Auto Insurance, FSCO’s statement indicated that, “[i]nterested parties are asked to identify issues and concerns and to provide suggestions that will improve Ontario’s automobile insurance system”. In an attempt to more fully identify issues, concerns and provide suggestions from the perspective of those who provide clinical assessments and treatments as well as Insurer Examinations regarding proposals for patients with psychological impairments, we have conducted a specific survey.

We present data here from the first 100 respondents. It is our understanding that this represents about half of all the psychologists in the province working with patients injured in auto accidents. As such, it should be considered a robust sample of these experiences. We believe that this data provides compelling information on the functioning of the system for the most vulnerable clients who are seen by our members. We will be using this data to speak to the issues of cost controls, consumer protection, specific SABS provisions, dispute resolution, and other issues, as identified in the terms of reference for the review.

**Patient experience with the auto insurance system**

First, in terms of patient care, psychologists reported in overwhelming agreement that their patients are either experiencing difficulty (57.6%) or extreme difficulty (29.3%) with the accident benefits system. Many reported that patients expressed extreme frustration regarding challenges they face to receive benefits they required to recover from their injuries.

<table>
<thead>
<tr>
<th>1. According to what patients have told you, how well does the system work for them?</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Well</td>
<td>4.0%</td>
<td>4</td>
</tr>
<tr>
<td>Satisfactorily</td>
<td>10.1%</td>
<td>10</td>
</tr>
<tr>
<td>With difficulty</td>
<td>57.6%</td>
<td>57</td>
</tr>
<tr>
<td>With extreme difficulty</td>
<td>29.3%</td>
<td>29</td>
</tr>
</tbody>
</table>

Can you provide examples of what patients have told you? 73

answered question 99

skipped question 1
This is very troubling, since it means that our most vulnerable patients are struggling with the system that is meant to be serving their needs. This may represent a small number of the patients who are accessing accident benefits under the SABS, but they are also likely to be the most vulnerable, and most likely to drop out due to frustration and therefore need to be picked up by the public system. In this way, consumers and Ontarians as a whole are not being protected by a system that creates barriers for its most vulnerable members. In order for benefits to truly be available for those who need them, they must be accessible easily when needed; currently, our vulnerable patients are indicating to their psychologists that they are not finding the accident benefits system to be available to meet their needs, or fair given the investment they have made in the Accident Benefit system to provide for their rehabilitation.

We also requested comments as part of this survey. In terms of patient experiences with the system, a number of common themes emerged reflecting frustration and unreasonable delays and blocks in being able to access treatment and receive income replacement and other benefits. Psychologists indicated that their patients frequently report difficulty with paperwork and feel excessively challenged and unfairly treated by their insurers. Many of these comments suggest that patients report they are not being treated in a manner consistent with the expectations described in the Auto Insurance Consumer’s Bill of Rights, published by the Financial Services Commission of Ontario, which include the following consumer rights and responsibilities:

- You have the right to be treated fairly by your insurance company.
- You have the right to prompt and fair handling of claims.
- You have the right to receive information about accident benefits.
- You have the right to dispute your insurance company’s refusal to pay benefits.
- You have the right to choose your health care provider.
- If you receive accident benefits from your insurer, you must participate in treatment and rehabilitation, and try to get back to work.

(See Appendix A for the full Bill of Rights).

We believe that the aspirations of this Bill of Rights are appropriate when contemplating the provision of treatment and rehabilitation services within a health care system. Unfortunately, the data indicate that the reality of this system is very different for our patients and the system is not meeting this goal.

This report of patient experiences must inform our contemplation of any changes to the accident benefit system. While it may be timely to seek ways to create greater cost efficiencies and controls, these controls cannot be achieved at the expense of those who are injured and rely on fairness in the working of the insurance system to provide benefits and payment for services to facilitate their return to pre-accident health and function.

Affordability and availability of treatment and rehabilitation benefits: Timely and efficient psychological care
Clinical research indicates the value of timely identification of referring a patient for psychological assessment and treatment. However, because psychological impairments
tend to be under-identified and psychological interventions under-utilized, and particularly in relation to auto accident injuries, this value is often not realized. Failure or delays in identifying and addressing the psychological aspect of a person’s injuries often results in increased impairment and disability, delayed recovery, and increased personal and social costs. (See discussion in Companion Document to: Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims, January 10, 2005 -Appendix C)

Present Pattern:
In order to ensure the efficiency of an effective, affordable, and accessible auto insurance system that meets the needs of its consumers, it would be our desire to see a movement toward earlier referral for psychological assessment that is consistent with the scientific literature; however, there is no indication that this is happening. Psychologists report general stability in the timing of initiation of assessment and treatment over the past two years.

More specifically, psychologists report none to very few patients seen in the immediate post MVA period (0-6 weeks), slightly more in weeks 6-12, the largest group of patients in the 12 month to two year period post motor vehicle accident, and fewer patients first seen more than two years post motor vehicle accident.

<table>
<thead>
<tr>
<th>Time</th>
<th>Modal % of psychologists</th>
<th>Estimated referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>First week</td>
<td>97%</td>
<td>0%</td>
</tr>
<tr>
<td>1 - 6 weeks</td>
<td>55.40%</td>
<td>0%</td>
</tr>
<tr>
<td>6-12 weeks</td>
<td>32.40%</td>
<td>1 - 5%</td>
</tr>
<tr>
<td>12 - 24 weeks</td>
<td>32.40%</td>
<td>10 - 25%</td>
</tr>
<tr>
<td>24 - 52 weeks</td>
<td>39.70%</td>
<td>10 - 25%</td>
</tr>
<tr>
<td>1 – 2 years</td>
<td>34.70%</td>
<td>25 - 50%</td>
</tr>
<tr>
<td>2 - 3 years</td>
<td>27.30%</td>
<td>1 - 5%</td>
</tr>
<tr>
<td>&gt; 3 years</td>
<td>46.90%</td>
<td>1 - 5%</td>
</tr>
</tbody>
</table>

Most psychologists estimate receiving no referrals within the first 6 weeks after an MVA; very few are estimated to be referred within the first 12 weeks (3 months).

Close to 100% of estimated referrals are between 3 months (12 weeks) and 2 years.

Very few are estimated to be referred after 2 years or more post-MVA.

Because the duration criteria for diagnosing chronic PTSD and persistent mild TBI symptoms is more than three months, this referral pattern may make sense for some
conditions. However, a large proportion of injured people have vulnerabilities toward, or actually had, depression or anxiety that existed prior to the accident, that put them at risk for experiencing increased difficulties as a result of the MVA and the changes in their lives that it precipitates. These injured people represent a significant proportion of those whose injuries do not resolve as expected (see neck pain data), and who require earlier referral for psychological services.

We are also reminded that current definitions for chronic pain use 6 weeks as the point at which one determines chronicity. Given that this is the case, early referral in order to avoid chronicity should be occurring earlier than the current 3 months – 2 years that is identified in the data. In addition, problems with role changes due to physical limitations may begin immediately after the injured person tries to resume usual activities post-MVA. Given that people with vulnerabilities should be referred as early as possible, referrals of these patients should be made before 6 weeks to prevent chronicity of pain. Late referral should probably be the exception, not the rule, if we want to meet patient needs and maximize the efficiency, effectiveness, availability and affordability of benefits for consumers.

**Barriers to availability of rehabilitation benefits**

Given the desire to ensure availability of benefits to injured people in need, the OPA decided that it was especially important to ask our members about any perceived barriers to accessing assessment and treatment services for rehabilitation. Unfortunately, the vast majority of psychologists (97.6%) reported that their patients (either always, frequently, or sometimes) encounter barriers in the identification of psychological impairments or psychological factors relevant to their rehabilitation; very few suggested that their patients either “rarely” or “never” experienced such barriers to accessing needed services.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>3.7%</td>
<td>3</td>
</tr>
<tr>
<td>Frequently</td>
<td>81.7%</td>
<td>50</td>
</tr>
<tr>
<td>Sometimes</td>
<td>32.1%</td>
<td>26</td>
</tr>
<tr>
<td>Rarely</td>
<td>1.2%</td>
<td>1</td>
</tr>
<tr>
<td>Never</td>
<td>0.9%</td>
<td>0</td>
</tr>
<tr>
<td>Don't know</td>
<td>1.2%</td>
<td>1</td>
</tr>
</tbody>
</table>

Again, this is troubling, since it means that the clients who are most likely to give up due to psychological vulnerabilities are experiencing significant barriers to accessing the very treatment that might help them make better use of available services (including reductions in use of future services).

The barriers described included many that may be addressed by changes of practices, for example: lack of awareness by physical treatment providers of potential funding for
psychological services for persons with auto accident injuries; too much paper work and too many complicated forms; insurer and insurer examiner excessive/inappropriate denial of psychological assessments required to plan treatment; delays built into the application, review, and dispute resolution processes. Several of these issues may be resolved by education, reduction of administrative burden for patients, and new expectations and guidelines for the application, review, and dispute resolution processes.

Other factors identified as barriers include a lack of awareness of psychological factors; stigma and cultural barriers to identifying psychological impairments; physical treatment providers focus on specific areas of injury; and linguistic and cultural issues and a lack of psychologists who can respond to these populations in their language with knowledge of the culture. Several of these issues may be difficult for to address in this review, since they touch on more general concerns that fall outside the SABS.

**Recommendations**

In order to address some of these barriers and protect consumers by improving the availability of treatment and rehabilitation benefits, we recommend partnering with other stakeholder organizations to create ongoing educational opportunities for multi-disciplinary education regarding treatment and rehabilitation of patients with motor vehicle injuries that may help physical treatment providers to make more timely identification of psychological factors.

In order to address lack of awareness and identification of psychological factors by other providers, we also suggest that consideration be given to utilization of an instrument similar to the one available in the WSIB programs of care to assist in the identification of when a consultation regarding “psychological factors” may be indicated. Greater awareness and use of such an instrument early in the process by physical treatment providers may facilitate more timely identification and referral for psychological consultation. Implementation of this screening instrument will require further inter-professional education (see Appendix D).

We also recommend reducing the administrative burden on injured people where possible, and keeping them informed of the process, without requiring additional work by them in order to access benefits. Improving the quality of OCF-22 and 18 applications, communication between adjusters and proposers of assessment and treatment plans, and the dispute resolution process will also help address the other barriers noted by our members as special challenges for our patients. We make some specific recommendations regarding each of these later in this paper.

Remember that our members are responding to services provided to only 2-4% of all people injured in automobile accidents. Our data are showing that these most vulnerable people are overburdened, dissatisfied, and challenged by the system that is meant to return them to function. When barriers to availability of services are removed, affordability and cost-effectiveness are improved, resulting in a more effective rehabilitation system. Such a system meets the needs of the most vulnerable injured
people and does not offload chronic and more difficult cases in the long term to the public system.

**Applications for Approval of Assessment (OCF 22s)**

Affordability, availability, and consumer protection concerns regarding Applications for Approval of Assessments

*Too many assessments*

Part of the difficulty in recommending earlier identification and treatment of psychological factors involves the fact that this will generally also mean earlier and perhaps more OCF-22 applications for assessment for some patients. Although this may not sound like a problem in and of itself if it addresses patient need better and reduces impairments, disability, and associated costs to the system, we understand that there has been a great deal of concern expressed regarding a “deluge” of inappropriate and excessive Applications for Approval of Assessments (OCF 22s). Clearly this is not what we are proposing, and consistent with our overriding concept of putting patient needs first, we also want to find ways to reduce any applications that are inappropriate and excessive, since this creates a drain on the services that are needed, reducing the availability and affordability of benefits and violating consumer protection.

This issue is causing significant concern, as was recently reported in the Toronto Star (James Daw, “Medical assessment costs ‘frightening' insurers”, July 5, 2008). The following is an excerpt from his article:

> *Medical assessments are gobbling more of your auto insurance premiums. So insurers point to the cost as an enemy of stable premium rates in Ontario, while lawyers see a possible source of funds for innocent accident victims. The assessment cost is not large in proportion to the $8.1 billion in premiums Ontario motorists paid last year, but it has risen rapidly from $201 million in 2004 to $313 million last year. "If our goal is to control costs, we have to ask why," says Don Forgeron, Ontario vice-president of the Insurance Bureau of Canada, who supplied the figures.*

> *The cost of assessments is about 60 per cent of what insurers spent on treatments, points out Robin Spencer, president of Aviva Canada Inc. "That is a frightening figure," he says…. Toronto lawyer Richard Halpern, chair of the Ontario Bar Association’s auto insurance reform group, agrees with insurers that "assessments are a gargantuan drain in the insurance system." …Insurers must pay for a medical assessment before they can deny or cut off a benefit for income replacement, physical rehabilitation, housekeeping expenses, home renovation or other benefits. They must also pay for assessments the injured person may arrange to contest the denial of benefits. This system of duelling assessments replaced the former system of independent Designated Assessment Centres in 2004. It is one of many items up for discussion in a five-year review of the highly regulated auto insurance product.*

(See Appendix E)
Unfortunately, confusion results when the costs of all assessments are considered as a single entity as in the James Daw article. To facilitate finding solutions to the concern regarding the “costs of assessments”, there first is a need to distinguish between the various types and purposes of assessments. There are assessments initiated by the patient’s treating health professionals to diagnose impairments and plan treatment and complete other benefit applications. There are also assessments initiated by the insurer, for utilization review. These Insurer Examinations are obtained when the insurer wishes their own opinion if they are considering denial of an Application for Approval of an Assessment, a Treatment Plan, or other application. Unfortunately, present data does not allow us to distinguish between these various types of assessments in order to determine with any certainty what is driving either the cost or the concern.

**Caps and restrictions: a solution?**

In order to address these concerns, various stakeholders have suggested absolute controls, caps, and restrictions on assessments for injured people. Such suggestions have included for example, imposing a limit of a single assessment or dollar amount for all assessments, either in total, or in a certain time period for each injured person. Some have proposed caps on assessment for patients with “minor” injuries, or excluding only patients who are determined to have a catastrophic impairment from caps.

We would suggest that Applications for Approval of Assessments (OCF 22s) and the subsequent assessments to prepare Treatment Plans (OCF 18s) are an integral part of the treatment/rehabilitation process, and not realistically amenable to the kinds of caps and restrictions that have been proposed.

**Simultaneous and sequential applications**

Keeping the needs of injured patients first in our minds, multiple simultaneous as well as sequential assessments may be necessary for a subset of patients for a number of very valid reasons. The kind of patients with complex and difficult needs who are referred to psychologists often require several assessments over time to determine which impairments resulted from the MVA, how they are affecting the functioning of the whole person, to prepare plans for treatment, to determine how specific impairments are changing over course of recovery from accidents, and applications for other benefits. It is always our hope that as our patients improve, this is reflected in their assessment results over time, and their assessments for other benefits change as a result.

There are various patient situations wherein simultaneous Applications for Approval of Assessment (OCF 22) from separate health professionals/facilities are indicated. We include examples of simultaneous and sequential applications for approval of assessment.

1. **Simultaneous separate Applications for Approval of Assessments (OCF 22s)**

The patient presents to their family physician with symptoms that suggest post traumatic stress, anxiety and depression indicating a need for consultation regarding a psychological assessment, as well as, continuing physical impairment suggesting a need
for assessment to plan treatment by a physiotherapist. Following appropriate
determination whether an assessment is reasonably required, separate Applications for
Approval of Assessment (OCF22) are simultaneously submitted by a psychologist and a
physiotherapist.

It is important to note, that in each of these OCF 22s the health professional proposing
the OCF 22 indicates information regarding the other assessments and treatments being
provided to the patient. The assessment proposal may also include consultation and
coordination with the other health professionals as a component of the assessment
process. However, it is not reasonable to require that these separate Applications for
Approval of Assessments be submitted as a single multi-disciplinary proposal. Our health
care system includes many single health professional and single discipline treatment
facilities. These facilities have no financial interest in the operation of the facilities
operated by health professionals of other disciplines. In fact, for psychologists in Ontario,
the requirements for Health Profession Corporations specify that all of the share holders
of the corporation must be members of the College of Psychologists.

Patient choice and the referring health professional’s ability to select the specific health
professional(s) who are most appropriate to respond to the individual patient’s situation
are optimized through the selection of individual professional(s)/facility(ies). In addition,
working with different health professionals/facilities may increase patient accessibility
and treatment efficiency/effectiveness in that the patient is not limited to receiving
services from only large multi-disciplinary facilities.

By simultaneously assessing and addressing the physical and psychological aspects of the
patient’s treatment and rehabilitation needs, the combined treatment is most likely to be
efficient and effective. This multifocal approach is in the best interest of the injured
person for restoring the health. It also is cost effective in that the patient would be less
likely to benefit from either intervention in isolation if the other aspect of their problems
was not also addressed. In addition, more effective treatment and rehabilitation will
reduce costs associated with prolonged disability.

In contrast, it may be reasonable for simultaneous Applications for Approval of
Assessments submitted by a multi-disciplinary facility to be submitted as a single multi-
disciplinary application.

2. Regarding sequential Applications for Approval of Assessment by the same
health professional or health discipline

A patient may have received psychological and physiotherapy assessments and
subsequent treatment. They may have benefited from these interventions to the extent
that they are ready to return to work. However, there may be a new need for
psychological assessment regarding vocational issues for further vocational rehabilitation
planning if the patient’s continuing physical impairments preclude returning to the type
of jobs for which they had previously been qualified. Consider for example, a patient
with limited English language literacy and computation skills who had consistently
worked in a job requiring specific and demanding physical capacities. Their physical and psychological functioning may be sufficiently restored to perform activities of daily living and most homemaking tasks but they can no longer perform heavy, repetitive, overhead work, which their job required and no modified work is available. They may no longer require housekeeping assistance or physical treatments, however they are continuing to depend on Income Replacement Benefits.

In this situation, an application for Approval of Assessment for a transferrable job skills assessment may be indicated. If this assessment does not lead to identification of alternative employment, a further Application for Approval of Assessment from a psychologist for a psychological assessment regarding vocational issues to aid in development of a plan to return to alternative employment may be reasonably required.

**Caps: effects on patient care and availability of benefits**

Any numerical cap on assessments would be arbitrary and unrealistic, not reflecting the needs of patients and addressing them appropriately in order to ensure effective rehabilitation. A low cap would discriminate against those claimants with needs above the cap, even a high cap might continue to fail to meet the needs of some and would be excessive for many. We also note that because the assessment application is the first step in determining eligibility for assessment for benefits, it is essentially impossible to place controls on assessments without creating a de-facto denial of treatment and other benefits. As a result, it is our opinion that any use of caps must be rejected as contrary to the restorative purposes of the SABS according to the needs of the individual patient, and an unrealistic way to try to meet the needs of injured people.

We understand that there have also been suggestions to bring in a time-based cap or additional limitation that assessments could only be conducted within a specific time frame post MVA. Any such suggestion must also be rejected. It is clinically necessary to be able to assess changes in the injured person’s functioning over time in order to plan treatment and rehabilitation over the course of their rehabilitation. While there is some ability to predict the rehabilitation trajectory for groups of patients, these trajectories cannot be used to plan treatment for the individual patient. Restriction on assessments to a certain time period which is shorter than the benefit limits would de-facto preclude the ability to apply for treatment or other benefits making the availability of these benefits meaningless. The consumer’s ability to continue to seek treatment and rehabilitation that is reasonably required must be protected. In addition, if access to assessments ended early in the benefit period and interfered with access to treatment and other benefits, the burden and costs of care for these patients would be transferred to OHIP and the public system.

**Recommendation: Improved control through increased health professional accountability**

Standards of professional practice and the SABS requirements preclude health professionals from providing treatment without first assessing the patient to determine if the impairments presented are due the MVA, the specific nature of the impairments, the specific situation of the patient, the goals of the treatment, and the most appropriate interventions for this patient, as well as several other factors. These clinical assessments,
in and of themselves, are of therapeutic benefit to the patient as the assessment helps the patient to gain an understanding of their present situation and a sense of control through a plan for engagement in their treatment and rehabilitation. (See Appendix F). Keeping patient needs first in order to improve the effectiveness of the system, we do not see a realistic way to limit this process and still meet all the regulatory and professional requirements for this kind assessment prior to proposing or providing treatment.

We do have some suggestions that appear to be clinically sound and increase health professional accountability, which, would improve the quality of the Applications for Approval of Assessments without discriminating against those with more complex presentations or increasing the burden on the patient. If additional steps to increase health professional accountability that strengthened the application were taken, fewer “inappropriate” applications would be submitted, making the system more efficient. This approach would provide consumer protection to access reasonably required assessments for restoration of health and at the same time provide cost controls.

Psychologists’ responses to our survey on this issue indicated that they felt present practice for Applications for Approval of Assessments could be improved. First, with regard to who is submitting the applications, fully two thirds of psychologists indicated that a health professional of another discipline or a non-health professional sometimes obtains the information from the patient and patient consent for the assessment, despite the fact that it is a proposal for psychological assessment.

| 7. In your experience who is responsible for documenting the patient information and consent on the Application for Approval of Assessment (DCF 22)? |
|---------------------------------|-------------|-------------|-------------|-------------|-------------|-----------------|
|                                  | Always      | Frequently  | Sometimes   | Never       | Don't know  | Response Count  |
| The health professional proposing the assessment (or a health professional of the same discipline as the proposed assessment) | 53.6% (43) | 33.8% (27) | 10.0% (8)  | 0.0% (0)    | 2.5% (2)    | 80               |
| Health professional of another discipline only | 0.0% (0)    | 5.3% (3)   | 57.8% (33) | 26.3% (15) | 10.5% (5)  | 57               |
| Clinical or administrative personnel only | 3.6% (2)    | 10.7% (8)  | 32.1% (16) | 39.3% (22) | 14.3% (8)  | 66               |
| answered question                |             |             |             |             |             | 81               |
| skipped question                |             |             |             |             |             | 19               |

However, when asked about what they felt would be “best practice”, an overwhelming 90% indicated strong agreement that the health professional completing and documenting the information and consent from the patient should at least be from the same discipline as the proposed assessment.
Psychologists also were uniform in their agreement that it is reasonable to require more specific documentation of the health professional’s contact with the patient on the OCF 22 Application:

Given the importance of confirming patient consent and ensuring that patients are fully aware of all proposals submitted on their behalf, psychologists also indicated agreement that patients should receive a copy of the OCF 22 at the same time that it is sent to the insurer.

Adding these requirements (a health professional of the same discipline as the proposed assessment must submit the proposal; the health professional obtains information from the client, documents this fact and signs the proposal; and, a copy of the proposal is sent to the client) will improve the quality of assessment applications, thereby reducing the
number of inappropriate Applications for Approval of Assessment without increasing patient burden. These additional requirements are more realistic ways to improve the efficiency of the system that continue to keep patient needs first and ensure consumer protection and availability of benefits.

The prevailing model for provision of assessment and treatment of separate proposals from single discipline assessment and treatment providers/facilities must be maintained to protect patient choice and accessibility. However, where multi-disciplinary facilities are submitting simultaneous applications, it is our recommendation that proposals should be submitted as a single integrated application. This recommendation speaks to a concern that several simultaneous applications from multi-disciplinary facilities have been described as problematic for the system.

In the case of these multi-disciplinary facilities, we would suggest that the single application include all of the assessments to be conducted by various health professionals in that facility. In addition, it is reasonable to expect that the various health professional disciplines each have documented contact with the patient in order to obtain information required to complete the application. To confirm this patient contact, the single OCF-22 should be signed by each of the health disciplines of the proposed multidisciplinary assessment.

The insurer would be presented with a single integrated multi-disciplinary OCF 22 from the facility. Depending upon the nature of the proposed assessments it might be professionally appropriate for the IE to be carried out by a single assessor with the appropriate qualifications to address all of the assessments in dispute. In other instances, carrying out the IE might require a “primary assessor” and “consultants” regarding assessments by other professions, or multiple IE paper reviewers.

This integrated approach for OCF 22s from a multi-disciplinary facility would provide greater clarity and cost savings over multiple disparate OCF 22 applications from that facility and separate Insurer Examinations. It also would address duplications and overlaps in the multiple simultaneous OCF 22 proposals from a multi-disciplinary facility and reduce redundancy in the IE examination process. This would improve efficiency and consumer protection, while providing cost controls to ensure availability of benefits for injured people and not creating further burdens and barriers to care.

The option to use a “primary assessor” and “consultants” or multiple assessors in an integrated Insurer Examination, when indicated, also protects insurers against violation of the UDAPS provision that an insured person not be asked to attend for an examination under section 42 of the Schedule conducted by a person whom the insurer knows or ought to know is not reasonably qualified by training or experience to conduct the examination.

**Recommendation: Improved control through increased adjuster accountability**

Returning to our survey, psychologists have indicated that adjusters usually do not call them to discuss an assessment proposal when there is a problem with the application and the adjuster is considering referral to an IE. If the insurer has questions about an OCF 22,
a call to the proposer might result in clarification and approval. Conversely, if the adjuster had information that the psychologist had not considered, it might result in withdrawal of the application. Both alternatives would resolve some situations without requirement of an Insurer Examination, saving time and costs to the system.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>1.3%</td>
<td>1</td>
</tr>
<tr>
<td>Frequently</td>
<td>3.6%</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1.3%</td>
<td>1</td>
</tr>
<tr>
<td>Rarely</td>
<td>30.4%</td>
<td>24</td>
</tr>
<tr>
<td>Never</td>
<td>48.1%</td>
<td>38</td>
</tr>
<tr>
<td>Don’t know</td>
<td>15.2%</td>
<td>12</td>
</tr>
</tbody>
</table>

The majority of psychologists also reported that adjusters “rarely” or “never” provide specific reasons for not approving an application before referring to an IE. This leaves psychologists who are trying to provide reasonable and necessary services to vulnerable patients without any communication or corrective feedback regarding what might have been wrong with their proposal and how to fix it, so that the patient continues to have access to the needed service. If the adjuster does not approve the OCF 22 and requires the Insurer Examination without sound reason, this causes unnecessary assessment costs to the system, reduces efficiency, and delays or blocks patient access to services. If specific reasons were required before referring to an IE, these would help to guide more informed consideration of the application as well as the health professional’s ability to respond to any concerns, ensuring that costs are reasonable and realistic to meet the needs of the injured person. Again, it is important to bear in mind that none of these recommendations add to the burden experienced by the patient.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>2.9%</td>
<td>2</td>
</tr>
<tr>
<td>Frequently</td>
<td>3.8%</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>17.7%</td>
<td>14</td>
</tr>
<tr>
<td>Rarely</td>
<td>41.8%</td>
<td>33</td>
</tr>
<tr>
<td>Never</td>
<td>26.3%</td>
<td>20</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8.9%</td>
<td>7</td>
</tr>
</tbody>
</table>

answered question 79
skipped question 21
The comments that were provided as part of this survey indicate psychologists’ opinions that some insurer practices seem to be arbitrary and unreasonable when it comes to approvals and denials of assessment proposals. In particular, they noted that the number of approvals and Insurer Examinations required by insurers seems to vary greatly by insurance company, regardless of what is in the assessment application:

“Largely it seems arbitrary, as no real reason is ever given”;
“Sometimes denials seem arbitrary”;
“Some denials are made without explanation, so it is difficult to know if it is arbitrary”;
“Some adjusters respond in the negative to almost every OCF-18 or OCF-22. There does not seem to be any penalty for them in doing this, so why not?”;
“Some adjusters seem to automatically reject OCF-22 forms without consideration of content, preferring instead to defer decision of necessity of assessment to IE”.
“Some insurers do seem more likely to deny plans”;
“Particular insurers have shown a predictable pattern of OCF-22 rejections”;
“Some insurers seem to have a practice of automatic denial with no consideration of the specific case”;
“Particular insurers reject applications almost routinely”;
“[Insurer X] is notorious for denials”;
“[Insurer X] often will deny any submission that is sent to them”;
“[Insurer X] seems to routinely reject applications”;
“[Insurer X] rejects applications the most”;
“[Insurer X and insurer Y (a subsidiary)] reject more”;
“Certain companies like [insurer X] just deny OCF22s”.

We recognize that it might take more time to review applications if the improved communication between adjusters and psychologists proposing assessments that we are recommending were to occur. While psychologists have indicated their opinion that the present three days for the adjuster to review the Application for Approval of Assessment is appropriate, we have heard from some insurers that the three-day limitation interferes with their ability to fully consider the application. Clearly, this issue may require further multi-stakeholder consideration.

<table>
<thead>
<tr>
<th>17. Please describe your understanding of the reasonableness of the time line — 3 days — for the adjuster's review of the Application for Approval of Assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Too Long</td>
</tr>
<tr>
<td>Appropriate</td>
</tr>
<tr>
<td>Too Short</td>
</tr>
</tbody>
</table>

Please include any suggestions to modify the time line for the insurer's review. 22
answered question
skipped question 22

Our members are considering their patients’ needs and are voicing their concerns regarding any additional delays to availability of services when their patients are already so challenged by the system. We are mindful of the fact that it is important to balance time for the adjuster to do a reasonable review of the application with the delays involved
for the patient who must wait for the entire process to be completed prior to initiating the assessment. Electronic submission when this is again possible should further facilitate the process. Because of our concerns regarding any addition to the already existing delays experienced by patients in accessing their benefits and rehabilitation, it is our opinion that any extension of time lines for insurer review of an application must be coupled with expectations for an increase in insurer accountability including required contact with the proposer and provisions of reasons for considering denial. If timelines are increased, communication should be improved, so that the system maximizes efficiency and effectiveness of needed service delivery without burdening the patient.

**Recommendation: Improved control through increased Insurer Examiner accountability**

When we look at the pattern of approval/denial of assessment applications by IEs, we are not able to comment on the “correctness” of the decisions by the Insurer Examiners, as there is no quality control review mechanism built into the process.

In order to increase accountability of Insurer Examiners and consumer protection, psychologists indicate agreement regarding some criteria for determining if an Insurer Examiner is “reasonably qualified” to conduct an examination. These include years of experience, clinical practice relevant to the specific application in dispute, and health professional registration in the same discipline as the health professional completing the application. There is concern that if the Insurer Examination is conducted by a person who does not satisfy these criteria, the assessment is at greater risk of failing to meet basic standards of competence, objectivity and fairness. In addition, the opinion is less likely to be credible and therefore less likely to resolve the dispute.

<table>
<thead>
<tr>
<th>25. Please indicate which of the following criteria should be considered when determining if an Insurer Examiner is “reasonably qualified” to conduct an examination.</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of experience</td>
<td>33.3% (24)</td>
<td>54.2% (39)</td>
<td>9.7% (7)</td>
<td>2.6% (2)</td>
<td>0.0% (0)</td>
<td>72</td>
</tr>
<tr>
<td>Clinical practice relevant to specific application in dispute</td>
<td>85.3% (64)</td>
<td>13.3% (10)</td>
<td>1.3% (1)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>76</td>
</tr>
<tr>
<td>Health Professional Registration in same discipline as the health professional completing the application</td>
<td>85.3% (64)</td>
<td>10.7% (8)</td>
<td>2.7% (2)</td>
<td>0.0% (0)</td>
<td>1.3% (1)</td>
<td>76</td>
</tr>
<tr>
<td>Health Professional Registration in same discipline and with the same area of competence declared with the College as the health professional completing the application</td>
<td>64.0% (48)</td>
<td>29.3% (22)</td>
<td>4.0% (3)</td>
<td>1.3% (1)</td>
<td>1.3% (1)</td>
<td>79</td>
</tr>
</tbody>
</table>

Please comment on any standard or guideline that you recommend to identify that the Insurer Examiner is “reasonably qualified” by training or experience to conduct the examination.

Answered question 77

Skipped question 23

At this time, there is no provision in the SABS for payment for phone consultation between the Insurer Examiner and the health professional proposing the Application for Approval of Assessment. Psychologists indicated that the phone consultation rarely if ever occurs at this time.
Psychologists indicated their agreement that there should be payment provided for phone consultation between the Insurer Examiner and the Health Professional proposing the Application for Approval of Assessment.

They also indicated agreement that this phone consultation should be an expected component of the Insurer Examination and that the patient’s explicit consent for the consultation should be included on the OCF 22 form.
This phone consultation may increase accountability of both the health professional proposing the applications and the Insurer Examiner conducting the review. It would provide a mechanism to allow for clarification and may result in a more informed decision to withdraw or approve an application based on new information. More informed decisions would enhance consumer protection by facilitating approval of more appropriate applications. Utilization of phone consultation would also provide cost savings in some instances by resolving disputes rather than incurring continuing costs when further Dispute Resolution is involved.

**Recommendation: Improved control by increasing effective and efficient dispute resolution**

The decision of the Insurer Examiner to deny an application may not be challenged in further dispute resolution for a number of reasons, even if it is unsound and unreasonably leads to the denial of assessment and ability to apply for benefits. For example, the patient may “give up” on obtaining the services through the auto insurance system. Regarding their psychological impairments the patient turns to their family physician (if they have one) and therefore impedes the ability of family physicians to look after a broader population and take on more patients. In addition many of these patients are unable to obtain family physicians as they are viewed as requiring an excessively high level of services.

Delays in access to dispute resolution need to be addressed for it to provide a meaningful alternative for the patient whose assessment has been denied. In addition, some form of “help line” or other support may be required, particularly for claimants who have limited English language literacy and who find the paper work requirements overwhelming or intimidating. Thus, for consumer protection and timely restoration of health it is critical that a “Fast Track” mechanism and patient “support” be implemented to address denials of Applications for Approval of Assessments which are disputed by the patient.

**Treatment Plan Applications (OCF 18s)**

Psychologists’ responses to the survey indicated that many of their concerns about OCF-18 applications are the same as those experienced with OCF-22 applications. As a result, many of our recommendations to improve the affordability, availability of benefits, and consumer protection for assessment applications are the same for treatment applications.
Mechanisms to increase accountability of proposing health professionals, insurance adjusters and health professionals conducting Insurer Examinations will contribute to increased cost controls and consumer protection, improving affordability while reducing barriers to availability of benefits and continuing to keep the needs of injured patients first.

**Recommendation: Improved control through increased health professional accountability**

The majority of our members are clear in their mandate to keep the patient informed regarding their own care, making them a partner in the rehabilitation process, and ensuring their involvement. This is important clinically, but also serves to protect consumers from plans being submitted on their behalf without their knowledge or consent. In order to assure transparency and accountability for clinical and consumer protection purposes, psychologists agree that a copy of the Treatment Plan application should be sent to the patient at the same time that it is sent to the Insurer.

<table>
<thead>
<tr>
<th>32. Should the patient receive a copy of the Treatment Plan Application (OCF 18) at the same time that it is sent to the insurer for review?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>52.1%</td>
</tr>
<tr>
<td>Response Percent</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>30</td>
</tr>
</tbody>
</table>

**Recommendation: Improved control through increased adjuster accountability**

It appears that adjusters are denying first treatment plan applications and requiring Insurer Examinations with about the same frequency that they require Insurer Examinations of Applications for Approval of Assessment. Again, there is no independent quality assurance process to know what would be the correct number.

<table>
<thead>
<tr>
<th>34. In your experience, for what approximate percentage of first Treatment Plans does the adjuster not approve the application and require an Insurer Examination?</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-100%</td>
</tr>
<tr>
<td>1.3%</td>
</tr>
<tr>
<td>Response Percent</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Please describe any particular patterns you observe. Examples could include time post-MVA, cost, patient group (specific diagnoses or pre-existing conditions, socio-economic variables), arbitrary pattern of denials, particular insurers rejecting plans, etc.
It appears that fewer “subsequent” treatment plans are approved by adjusters and even more Insurer Examinations are required. This raises concerns regarding continuity of care for the injured person since the time lines for adjuster review, referral to the Insurer Examiner, Insurer Examiner assessment and report preparation, and adjuster time for providing a decision to the claimant, create a delay in knowledge of funding for further treatment even when all of the deadlines are met.

Increased adjuster accountability for the decision to deny a treatment plan requiring an Insurer Examination may result in greater consumer protection and timely access to treatment. In addition, by eliminating unnecessary Insurer Examinations, this accountability may reduce the cost burden on the system.

Some mechanisms that would increase accountability do not appear to be presently used with any frequency. We note that psychologists report that adjusters by and large are not contacting them if they are considering denying a Treatment Plan Application.

Similarly most psychologists report that adjusters only sometimes or never provide reasons for denying the Treatment Plan Application and requiring an Insurer Examination.
A requirement for the insurer to contact the proposer of the treatment plan with questions and specific provide reasons for any denials would help to address issues of consumer protection and cost control. More explicit communication and information exchange between the adjuster and the proposer might help the insurer to understand that a proposal was reasonably required, or alternatively might result in the proposer withdrawing the application. This would either facilitate more rapid access to treatment or save the burden and the cost of the Insurer Examination.

**Recommendation: Improved control through increased Insurer Examiner accountability**

Psychologists also reported strong agreement on criteria for determining that an Insurer Examiner is “reasonably qualified” to conduct an examination of a Treatment Plan. Uniformly requiring that these criteria be met would contribute to improved accountability of the Insurer Examination. The system fails to work to restore the health of the patient if the Insurer Examination fails to provide a fair and sound opinion. This creates unnecessary delays and blocks patients’ access to treatment. There is also the additional unnecessary cost to the system when the disputes are protracted due to a lack of credibility of the Insurer Examiner. It is recommended that consumer protection and cost savings would be accomplished by creating guidelines for health professional qualifications for Insurer Examiners. These guidelines would speak to the nature of the education, training, experience and current practice required to provide qualified opinions on assessment and treatment plans.
While payment is provided in the SABS for phone consultation between the Insurer Examiner and the health professional proposing the Treatment Plan Application, psychologists report that the provision for phone consultation is rarely utilized.

There is general agreement that phone consultation should be an expected component of the Insurer Examination. Phone consultation would increase accountability to provide consumer protection and cost savings when used for Treatment Plans similarly to when used in reviews of Applications for Approval of Assessments. For this phone consultation to occur in an expedient manner the patient’s explicit consent should be included on the OCF 18 Application form. Therefore, we are recommending that Insurer Examiners consult with the proposing health professional as an expected component of the Insurer Examination.
Recommendation: Improved control by increasing effective and efficient dispute resolution

When treatment plan applications are denied subsequent to an Insurer Examination, rebuttal examinations and reports help to increase the accountability of the Insurer Examiner and provide a measure of consumer protection. The rebuttal report may address errors in the methodology or the factual basis used for decision making. In this way, the rebuttal report may provide corrective feedback and immediate resolution of the issue. When this does not occur, the patient may rely on the rebuttal report for further dispute resolution. While some psychologists report that they always or frequently provide rebuttal reports, others report that they rarely or never complete these examination reports. The comments from psychologists seem to reflect frustration that there is no obligation for the insurer to consider and respond to the rebuttal report.
Quality Assurance and Improvement

Professional accountability and the role of the college
In the light of the fact that our profession is self-regulating, our college and professional associations publish regular updates of existing guidelines and standards meant to advise members on how to proceed in practice. Many such guidelines and standards exist for psychologists; from the broadest Code of Ethics for Psychologists, as published by the Canadian Psychological Association (2000), to very specific advice on “Considerations and Cautions” when providing services to victims of MVAs (College of Psychologists of Ontario, 1997). In fact, several publications exist to guide psychologists both in terms of general practice, and in terms of very specific concerns related to providing services under auto insurance.

OPA Guidelines
As a self-regulating profession, we have chosen to create guidelines and standards for the profession that advise individual members on their role as psychologists and how to behave. In particular, the Ontario Psychological Association has published guidelines which include specific reference to proposing assessments and treatment plans under auto insurance. Psychologists thorough out the province are known to use these guidelines in proposing and reviewing assessment and treatment plans. These guidelines refer specifically to several other publications applicable to working in the automobile insurance sector for psychologists in the province to be aware of when assessing and treating patients or proposing and reviewing proposals.

From the OPA Auto Guidelines and Companion:
“All Psychological assessment and treatment is subject to current professional standards and ethical principles, as identified by the Canadian and Ontario Psychological Associations, as well as the College of Psychologists of Ontario. Specific standards for ethical practice with regard to assessments and treatments under auto insurance have also been published by the College of Psychologists of Ontario, and disability assessment standards have been published by the Canadian Academy of Psychologists in Disability Assessment. Psychologists in all their practices adhere to the professional standards established by the national and provincial associations and the College. Psychologists practicing under auto insurance follow the relevant standards published by the OPA and the College. Psychologists practicing in this field should be familiar with relevant publications”.

It is important to note that the guidelines were developed after a rigorous review of the scientific literature, consensus review within the OPA Auto Task Force and by external reviewers doing work within the auto insurance sector, and finally, after peer review and adoption by the OPA Board of Directors. The Guidelines were therefore considered to be a reasonable representation of the expected community standards for the practice, given the state of the science and profession in Ontario at the time. They are meant to function as a sort of handbook for psychologists and others in the province to use when proposing or reviewing plans; ranges of generally acceptable limits for assessment and treatment
plan proposals are given, along with recommendations regarding what to include and how to complete the OCF-22 and 18 forms. Consistent with their intended use, the majority of respondents to our survey indicated that, in their experience, most psychologists are using the guidelines most of the time when proposing assessment and treatment plans.

Unfortunately, the data also indicate that most psychologists either can not tell if adjusters are using the OPA Guidelines, or indicate that their use is infrequent (“sometimes”, “rarely”, never”) (again, remember that reasons for approval or denial are rarely given, and communication between proposers and adjusters appears lacking).

Although Insurer Examiner use of the OPA Guidelines appears to be greater than reported adjuster use (55.4% report “sometimes”, “frequently” or “always” using the Guidelines), there still remains a large minority of respondents indicating that either IEs “rarely” or “never” use the Guidelines (13.5%), or they simply can not tell whether they do or not (31.1%) (remember again the concerns around lack of communication and rationale when denying proposals).
It is clear that many adjusters and reviewers of assessment and treatment plans (including reviewing psychologists) may not be using or citing the OPA Guidelines, as intended. It is possible that many adjusters and some reviewers may not be aware that such guidelines exist. We support the use of the OPA Guidelines and the development of further educational initiatives to help ensure that all proposers and reviewers of assessment and treatment plans – whether they are psychologists or adjusters, also utilize them to the fullest extent possible. If existing guidelines and standards were applied more regularly, these would increase accountability and reduce many disputes that arise in the current system. For example, if adjusters were familiarized with the OPA Guidelines, so that they had a guideline by which to judge the reasonableness of applications, perhaps more appropriate approvals and more selective referrals for IEs would result. Similarly, professional education and reminding any Insurer Examiners of the applicability of the current guidelines would improve the quality and credibility of the IE examination and report.

**Continuing education requirements**

Within the profession, the data suggest that many psychologists are interested in continuing education related specifically to working within this sector. The vast majority of respondents to our survey indicated their interest in attending and requiring additional educational sessions on work specific to auto insurance.
This appears to be an indication that, as a self-regulating profession, psychologists can take this opportunity to remind our members of the provisions within the existing guidelines, standards, and codes of conduct that apply to work under auto insurance, whether one is a proposer or reviewer of assessment and treatment plans. In this way, the members are voicing their opinion that increasing professional education specifically in this area is needed, and will likely improve adherence to already existing standards of conduct.

The OPA supports this suggestion. The Auto Task Force and the College of Psychologists will work together to provide ongoing guidance and education to members, updated articles and workshops.

**Unfair and Deceptive Acts or Practices: Enforcing greater accountability to enhance consumer protection and cost control**

The Unfair and Deceptive Acts or Practices (UDAPs) appears to be a mechanism that should be a powerful tool to provide cost control and consumer protection through increasing the accountability of health professionals proposing and providing clinical assessments and treatment, health professionals conducting Insurer Examinations and Insurers.

As far as could be determined, the UDAPs have rarely if ever been utilized regarding health professional or insurer behaviour. For the UDAPs to play an effective role, greater education regarding their application is necessary. An explanation for the public, health professionals and insurers posted on the FSCO website would be helpful. Clear directions regarding the process for determining applicability of the UDAPs and the steps to lodge a
complaint are also needed. In addition, it would be helpful if the contact people and procedures for a UDAPs complaint were clearly outlined on the website. At this time, it appears that there may be instances that health professionals and insurers behave in ways contrary to the UDAPs provisions. However, lack of familiarity with this process may have limited its utilization to date.

**Other mechanisms to increase accountability and control: Canadian Health Care Anti-Fraud Association**

The OPA is aware of concerns that exist within the government, insurance industry and our own profession regarding the potential for fraud with respect to accident benefit claims following MVAs. The OPA has, over the years, worked to minimize this possibility, by educating our members about the correct procedures and legislation surrounding accident benefit claims. We have also worked with the College of Psychologists to develop and ensure our members adhere to a strict code of ethics and practice guidelines.

In the future, we will continue in these efforts, and will explore working with organizations such as the Canadian Health Care Anti-Fraud Association (CHCAA) in an effort to ensure that services available clients with legitimate injuries are not limited because of a drain on the system from the few that would seek to exploit it.

The CHCAA’s vision is to improve the Canadian health care environment by eliminating health care fraud. We believe our existing efforts will fit nicely with the goals of the CHCAA and we can take advantage of their resources and knowledge to expand our educational and prevention programs. Additionally, an affiliation with the CHCAA will allow us to engage private insurance companies and government agencies to work towards improvements to existing processes, such as streamlining the OCF-22 forms, and enhancing communication between all parties involved.

**Areas of additional concern to psychologists**

The review invites us to address other issues of concern to psychologists. Returning patients to their pre-accident health and function is a central focus for health practitioners working within the auto insurance system. Patients enter assessment and treatment in the context of having been in an MVA, and typically present with ongoing physical and psychological impairments in relation to that MVA. As such, work in this area is characterized by a focus on the interaction and interconnectedness of the physical and psychological (body and mind).

Unfortunately, considerations under the current Catastrophic definitions in the SABS are outdated in this respect, artificially splitting mind and body and creating discriminatory situations with respect to people struggling with psychological impairments and pain conditions. As well, current language in regulation O.reg 461/96 as amended by O. reg 381/03 subsection 4.3 (3), which specifically calls for adducing evidence of one or more physicians, is also discriminatory and places burdens on the system and patients. While physicians are required to adduce evidence regarding physical impairments, it is entirely
appropriate to also allow the evidence of psychologists alone to support a claim of psychological or mental impairment.

**The mind-body connection – a context for understanding additional psychologist concerns**

Awareness of the interconnectedness of the mind and body is reflected in current science and standards of care. For example, although many people may think of pain as primarily a physical phenomenon, the International Association for the Study of Pain defines pain as “[a]n unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in such terms as damage.” This definition highlights the importance of the subjective experience of pain, and moves beyond previous distinctions between “somatogenic” pain (pain with origins in the body, or “real” pain) and “psychogenic” pain (pain with origins in the mind, or “imaginary” pain). Here we see an awareness that the distinctions made between mind and body over the last several centuries have become clearly outdated. A more contemporary understanding of pain recognizes the necessity of seeing the mind and body as unified in relation to a whole person.

Consistent with this, the threshold for permanent serious impairment that is contained in Bill 198 recognizes that impairments are not limited to the physical by including criteria for permanent and serious impairment of mental or psychological function. We also note that the World Health Organization’s International Classification of Diseases (ICD-10) and International Classification of Functioning, Disability, and Health (ICF) that are used by the SABS place all illness and disease (including mental and behavioural illnesses) within one system of coding. Mental/ emotional and behavioural disorders and impairments are not selected out and treated differently under these classification schemes. We note the inherent fairness and non-discriminatory nature of the SABS in using the ICD-10 for coding impairments, rather than a separate system, such as the DSM-IV. A dichotomous view between physical and psychological aspects of many conditions is regressive and a return to outmoded models of understanding the whole person in healthcare. Indeed, the data are clear in indicating that when the whole person is cared for effectively, future care costs decrease, and health delivery systems are less burdened over time.

There is an abundance of research that points to the critical role of psychological factors in overall health. For example, although it has been known for some time that Post-Traumatic Stress Disorder (PTSD) is associated with dramatically higher rates of chronic health problems and utilization of health services, a recent study published in the July issue of Psychosomatic Medicine (Boscarino, 2008), indicates that unresolved Posttraumatic Stress Disorder (PTSD) also increases significantly the risk of death due to heart disease. It must be noted here that MVAs are the single biggest source of PTSD in civilians, and that approximately 40% of people who have been injured in MVAs develop PTSD symptoms, a substantial minority of which do not resolve, even with the gold standard of treatment. As a result, obviously, public health and welfare plans carry the extra burden created by worse health outcomes, such as heart disease and premature death in those with PTSD post-MVA.
Depressive disorders, which are also commonly seen in patients who have been in MVAs, are also known to increase risks for later morbidity and mortality. For example, a meta analysis that appears in the International Journal of Geriatric Psychiatry (Van der Kooy, et al, 2007) cites clinically diagnosed major depressive disorder as the most important risk factor in developing cardiovascular diseases. A wealth of information regarding the impact of depression is also found in the Special Report to the Ontario Chamber of Commerce Economic Summit on Mental Health and Productivity, (Wilkerson, 2005). This report indicates that “[d]epression represents 12 per cent of the world’s calculated rates of disability, the principal single source.” The report also notes that mental disorders of the type we commonly see in auto insurance work (depressive and anxiety disorders) are “concentrated among men and women in their prime working years.” In other words, the impact of psychological disorders extends beyond the individual context and has enormous social impact. Since these psychological disorders are typically amenable to psychological treatment, ensuring early detection and proper treatment can effectively reduce the impact that these illnesses have on the individual and the rest of society.

Pain conditions are also regularly seen in auto insurance work. The Task Force on Neck Pain and Associated Disorders has presented a synthesis of their findings regarding best evidence in relation to neck pain (Spine, vol. 33, 4S, 2008). This research further highlights the interconnectedness of the various healthcare disciplines, and also of the healthcare system and other systems, and the overall importance of supporting a movement away from the biomedical model towards a more interconnected and multidisciplinary biopsychosocial model of healthcare. This works to reinforce the notion that any meaningful approach to healthcare will recognize the functioning of the whole person and will not artificially separate the mind and body. Psychological factors emerge in this research as being a most important factor with respect to the impact on the course and prognosis for patients with neck pain; these psychological factors are also presented as the most modifiable prognostic factors.

As pain advances from an acute to a chronic phenomenon, it can lead to the development of psychological impairments. Psychological factors can also change and play an increasingly important role in the perception of pain and how the person adapts and copes with it as it moves from acute to chronic. It is not surprising that depressive and anxiety disorders are prevalent in patients with chronic pain. We also know that psychological disorders play a role in triggering, maintaining, and exacerbating pain conditions. The interaction of these factors can form a vicious cycle, which psychology is uniquely positioned to treat; consequently, the expertise provided by psychologists to these patients has a prominent and critical role in the healthcare system.

Role of psychologists in the tort system and disability evaluations
As psychological and mental impairments are significant in a subset of insured crash victims, and because these impairments must be considered in many types of benefit applications and many tort claims, the skills and expertise of psychologists are often
called upon in accident benefit applications, insurer examinations, plaintiff and defense
tort assessments.

Catastrophic impairment determination
Diagnosis of psychological, behavioral, emotional, mental, and neuropsychological
impairment is also a critical component of the process of catastrophic impairment
determination. The SABS provide a higher policy limit for those with a catastrophic
impairment. The right to sue for future care in accidents before October 1, 2003 also
required that the plaintiff satisfy the catastrophic impairment threshold. Psychologists and
neuropsychologists have an important role in the analysis of several of the SABS tests:
- E(i), the Glasgow Coma Scale, a measure of level of consciousness;
- E(ii), the Glasgow Outcome Scale, a measure of functional independence;
- F and G, the AMA Guides Fourth Edition; wherein neuropsychological,
  neurocognitive, and psychological impairments are diagnosed and rated for their
  impact on function.

Although nowhere else in the SABS is there discrimination against those with
psychological impairments; the AMA Guides Fourth Edition presented challenges to the
drafters of the Bill 59 regulations, due to the discomfort of the authors of the mental and
behavioral chapter regarding quantification. This led to the current catastrophic
impairment SABS definition which appear to provide no mechanism for combining
bodily and psychological impairments. Judges and arbitrators have held that the “Whole
Person Impairment” ratings must be inclusive of psychological impairments.

During the process of review of the catastrophic impairment SABS definition, it is critical
that the current judicial and arbitral interpretation which respects the contribution of
psychological impairments to whole person ratings be maintained. We must not return to
a system which does not allow a true whole person impairment rating or one which does
not allow the insured’s psychological impairments to be combined with other
impairments. Discrimination against those with mental and behavioral impairments
should not be reintroduced in any revision of the catastrophic SABS.

Adducing evidence
We recommend reconsideration of the language in O. Reg 461/96 as amended by O. Reg
381/03 subsection 4.3 (3) which specifically calls for adducing evidence of one or more
physicians. In our experience, this requirement has already increased the costs and
burdens on the tort system, where it has been perceived that in addition to a psychologist
testifying about psychological and mental impairment, it is also necessary to adduce the
evidence of a physician. While physicians are required to adduce evidence regarding
physical impairments, it is also entirely appropriate to allow the evidence of
psychologists alone to support a claim of psychological or mental impairment.

We would be pleased to work with the government to draft language that more fairly
encompasses the professions who can diagnose impairments and provide evidence. We
provide the following further analysis of this issue.
The stipulation contained in O. Reg. 461/96 as amended by O. Reg. 381/03, s. 1, that an individual’s claim in tort law of serious permanent impairment must be supported by evidence of a physician is not only arbitrary, but is economically inefficient.

The current provision is arbitrary in the way that it requires additional evidence from a physician based solely on their designated degree without any regard to their expertise in relation to the ultimate issue to be addressed. In fact, this stipulation is rather anomalous in light of case law and other legislation pertaining to expert evidence. Typically, in determining whether expert evidence will be admitted to the court, the “Mohan test” is applied (see Appendix B) and is determinative of whether the court is able to rely on the expert evidence when deciding the ultimate issue. As David M. Paciocco and Lee Stuesser state in *The Law of Evidence*, “[…] the four part “Mohan Test” reflects the common law, and applies equally in civil and criminal cases. Ultimately the burden will be on the party calling the evidence to establish that, on the balance of probabilities, the evidence satisfies the Mohan Test”.¹ In effect, the Regulation can work to undermine an assessment made by the trier of fact in relation to the quality of evidence provided by an expert; this is because even if the trier of fact determines, under the “properly qualified” step of the Mohan test, that a psychologist is capable of providing an opinion on the claimant’s injury, the Regulation acts to demand that this evidence is further supported by physician evidence. Consequently, in many cases, the inclusion of a physician opinion is actually unnecessary and is obtained for the sole purpose of satisfying the regulation.

The approach that is often taken by the court, where the Mohan test is the sole test used by the court to determine whether the expert is qualified to provide evidence, is superior in that it confers the judge with a large amount of discretion in his or her consideration of the quality of the evidence presented by the expert. Because the Mohan Test compels the judge to determine whether evidence should be admitted on a case-by-case basis, including an assessment of how qualified the expert is to speak to the claimant’s injury, the regulation’s inclusion of an absolute requirement for physician evidence appears counterintuitive in that it reduces the influence of evidence provided by non-physician experts whose specific expertise in relation to the case at hand, has already been established by the court. Consequently, while it is conceded that psychologists are not properly qualified to provide evidence in support of some serious permanent impairment claims, specifically those relating solely to physical injury, the Mohan Test equips the judge to reject the evidence of a psychologist, or any other expert, who is not properly qualified to provide evidence in those particular circumstances.

At the same time, the Mohan Test would open the door to allow the evidence of psychologists to be sufficient in cases where the claim for serious permanent impairment is based upon a mental or psychological impairment; the ability for psychologists to testify in such cases is crucial as their expertise, owing to their specific education and experience in the field, often makes them the most qualified professionals to attest to such claims. Outside of this Regulation, the Canadian legal system has routinely acknowledged the valuable role of psychologists in providing evidence; for example,

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section 52 of the *Evidence Act*\(^2\) (see Appendix B) includes psychologists in its definition of practitioners who are qualified to provide a medical report relating to the action. Moreover, a review of Canadian case law reveals that courts, including the Supreme Court of Canada, are prepared to view evidence provided by psychologists as admissible, and often highly significant to the legal issue being addressed. For example, case law reveals that evidence provided by psychologists has been relied upon to support claims of “Battered Woman’s Syndrome”; in this way, the evidence provided by psychologists has a very weighty impact, reducing a criminal charge of murder to manslaughter.

As admissibility of evidence under the *Mohan* Test is, “[…] not determined by rigid, technical rules […], but on a case-by-case basis, because the needs of the case, or of the quality of the expert evidence about the expertise will vary […]”\(^3\) any anxiety relating to “precedent setting” is irrelevant; accordingly, the fact that psychological evidence is accepted by a judge in a claim of serious permanent impairment will not bind judges in any successive cases. Illustrative of this point is *R. v. Olscamp*\(^4\) where Justice Charron stated that despite an earlier ruling in *R. v. Burns*\(^5\) where the Supreme Court of Canada accepted the evidence of a psychologist in relation to a sexual assault victim, she did not consider herself bound “[…] on the question of whether similar evidence tendered in that case was reliable enough to admit”.\(^6\)

In addition to the fact that psychologists may be the most qualified professionals to provide evidence on whether a claimant’s mental or psychological impairment meets the threshold for serious permanent impairment, allowing claimants to rely on evidence provided by psychologists will also be less stressful for the claimant as well as more economical in many cases as it will reduce the number of professionals who are implicated in the determination of impairment. Under the current system, individuals with mental or psychological impairments who are already being assessed by a psychologist are compelled to undergo an additional assessment by a physician in order to gain support for their tort claim. By removing the stipulation that a physician is required to attest to such impairment, patients will be less constrained as they will be given a choice to be assessed by a psychologist alone; in cases where a patient has already been assessed or treated by a psychologist, or in cases where a psychologist’s evidence is essential to the claimant’s case, this revision will have the impact of reducing costs as patients will no longer be required to obtain an additional assessment by a physician just to fulfill the requirements of the Regulation.

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\(^3\) Paciocco and Stuesser, *supra* note 1 at 182.

\(^4\) 1994 CanLII 7553 (ON S.C.) at 18.


\(^6\) *Ibid* at 182-3.
Conclusion

The OPA is pleased to have this opportunity to respond to the Superintendent’s review of auto insurance. We have focused on the stated objectives of the review of affordability and availability of benefits, and consumer protection. We made recommendations for specific changes to the SABS and to dispute resolution processes, as requested. We also introduced concerns specific to psychology related to use of an outdated biomedical model of health that creates discrimination in the current regulations and legislation. In addressing each of these concerns, we have maintained a focus on putting patient needs first within the auto system, so that, consistent with the goal of the SABS, people are returned to pre-accident functioning, and their MVA-related needs are not offloaded to the public system as a result of incomplete care.

Highlights from our findings:

Psychologists reported overwhelming agreement that their patients are experiencing difficulty with the accident benefits system and feeling excessively challenged and unfairly treated by their insurers.

Most psychologists surveyed estimate receiving no referrals within the first 6 weeks after an MVA; very few are estimated to be referred within the first 12 weeks (3 months). Given that current definitions for chronic pain use 6 weeks as the point at which one determines chronicity, more timely referral in order to avoid chronicity should be occurring earlier than the current 3 months to 2 years that is identified in our survey data.

Unfortunately, the vast majority of psychologists (97.6%) reported that their patients encounter barriers and delays in the identification of psychological impairments or psychological factors relevant to their rehabilitation.

Psychologists surveyed indicated strong agreement: that the health professional completing and documenting information and consent from the patient should be from the same discipline as the professional who proposed the assessment; that it is reasonable to require more specific documentation of the health professional’s contact with the patient on the OCF 22 Application; and that patients should receive a copy of the OCF 22 at the same time that it is sent to the insurer.

Comments from psychologists reflect frustration that there is no obligation for the insurer to consider and respond to the rebuttal report.

Recap of our recommendations:

- We proposed methods for reducing applications that are inappropriate and excessive.
- We discussed why numerical and time caps for restricting assessments are problematic, interfering with rehabilitation and benefit applications, and how this
inevitably leads to offloading the burden and costs of care for patients to OHIP and the public system.

- We made suggestions for increasing health professional and adjuster accountability.

- We suggested that simultaneous OCF 22 applications from a single facility be combined into a single multi-disciplinary application. We also suggested the various health professional disciplines each have documented contact with the patient in order to obtain information required to complete the application. To confirm this patient contact, the single OCF-22 should be signed by each of the health disciplines of the proposed multidisciplinary assessment.

- We suggested utilization of phone contact between adjustors and proposing psychologists, as well as between insurance examiners and proposing psychologists with respect to applications.

- If timelines for reviewing applications are increased, we recommend that communication should be improved, so that the system maximizes efficiency and effectiveness of delivery of needed services without burdening the patient.

- For consumer protection and timely restoration of health, we recommended that a “Fast Track” mechanism and patient support such as a help line be implemented to address denials of Applications for Approval of Assessments, which are disputed by the patient.

- We recommended that the insurer contact the proposer of the treatment plan with questions and provide reasons for any denials. This would help to address issues of consumer protection and cost control.

- We also recommended that the IE reviewer be expected to contact the proposer with any questions, which may lead to clarification and approval of the application or withdrawal.

- We recommended guidelines for qualifications of Insurer Examiners to ensure that they have appropriate education, training, experience, and current practice to provide qualified opinions on the benefit applications provided by other health professionals. It is particularly important that the psychologist reviewing treatment plans be engaged in provision of treatment with the specific population in question in order to have the experience necessary to make informed comment.

- We are supportive of the development of a multi-stakeholder forum which can meet regularly to identify and address problems within the automobile insurance system. This forum can also be a vehicle for developing multi-stakeholder educational programs.
We are also supportive of the planned re-activation of HCAI. We believe that this will be a significant contribution to collecting sound, accessible data on the functioning of the auto insurance system. We also see this as a step toward using electronic processes to reduce transaction costs.

We also want to convey our support for the recommendations made by the Coalition Representing Health Professionals in Automobile Insurance Reform in their submission.

Quality assurance and improvement - professional accountability
In addition to our recommendations, our submission also detailed the many guidelines and standards that exist and are regularly updated to advise members how to proceed in practice. These include guidelines produced by the Ontario Psychological Association, which include specific reference to proposing assessments and treatment plans under auto insurance.

We reported on the opinion of psychologists around the province that increasing professional education specifically in this area is needed, and will likely improve adherence to already existing standards of conduct. The OPA supports this suggestion. The Auto Task Force and the College of Psychologists will work together to provide ongoing guidance and education to members, updated articles and workshops. Further multi-stakeholder education and collaboration is also recommended.

Our submission also addressed Unfair and Deceptive Acts or Practices (UDAPs), which appears to be a mechanism with untapped potential. The UDAPs could be a powerful tool to provide cost control and consumer protection through increasing the accountability of health professionals proposing and providing clinical assessments and treatment, health professionals conducting Insurer Examinations and Insurers.

Additional concerns addressed
The review invited us to address other issues of concern to psychologists. We indicated our concerns regarding the current Catastrophic definition in the SABS, as it provides no clear guidance for combining bodily and psychological impairments. Instead, it contains an outdated, artificial splitting of mind and body, and creates discriminatory situations with respect to people struggling with psychological impairments and pain conditions. In contrast, judges and arbitrators have held that the “Whole Person Impairment” ratings must be inclusive of psychological impairments. It is essential that that this discrimination, not be confirmed or reintroduced in any revision of the catastrophic definition.

As well, current language in O. Reg 461/96 as amended by O. Reg 381/03 s 4.3 (3), which specifically calls for adducing evidence of one or more physicians, is also discriminatory and places burdens on the system and patients. While physicians are required to adduce evidence regarding physical impairments, it is also entirely appropriate to allow the evidence of psychologists alone to support a claim of psychological or mental impairment.
We trust that our recommendations have addressed issues of affordability and cost control in the context of consumer protection and availability of rehabilitation benefits for restoration of health and function. We will be happy to discuss our analysis and recommendations further.
Appendices

Appendix A: Auto Insurance Consumer’s Bill of Rights
published by the Financial Services Commission of Ontario.

Consumers’ Rights

Ontario laws require all owners of automobiles to have auto insurance. These laws also give you rights as an auto insurance consumer. The following information highlights many of your rights under the Insurance Act, related laws and regulations.

1. You have the right to purchase auto insurance coverage.
2. You have the right to be treated fairly by your insurance company.
3. You have the right to be given written reasons if you have been denied auto insurance.
4. You have the right to keep your policy in place if you pay your premiums and meet the responsibilities.
5. You have the right to pay your auto insurance premium in monthly instalments.
6. You have the right to keep your policy in place if you pay your premium within 30 days following one or two non-sufficient fund (NSF) situations.
7. You have the right to be informed in writing if your policy is not being renewed.
8. You have the right to change or cancel your insurance policy at any time.
9. You have the right to remain with your insurance company even if that company no longer sells insurance through your broker.
10. You have the right to know from which companies your broker received quotes and the amounts.
11. You have the right to prompt and fair handling of claims.
12. You have the right to reasonable repair of your damaged vehicle.
13. You have the right to choose a repair shop, tow operator or vehicle rental company.
14. You have the right to receive information about accident benefits.
15. You have the right to dispute your insurance company’s refusal to pay benefits.
16. You have the right to choose your health care provider.
17. You have the right to register a complaint about your insurance company.

Consumers’ Responsibilities

1. You must insure your vehicle and retain your proof of insurance (pink slip) while driving.
2. You must pay your premium in a timely fashion.
3. You must give true and accurate information to your insurer and complete all forms promptly.
4. You must promptly let your insurer know about any change in circumstances that could affect your insurance situation, including if you are involved in any accident.
5. You must provide your insurer with updated information when requested. If you are claiming accident benefits, you must send your insurer a completed accident benefits package on time.
7. If you are claiming accident benefits, you must attend medical examinations requested by your insurer that are reasonably necessary to evaluate your claim.
8. If you receive accident benefits from your insurer, you must participate in treatment and rehabilitation, and try to get back to work.

**Appendix B: Adducing evidence**

*R. v. Mohan, 1994 CanLII 80 (S.C.C.)*

Admission of expert evidence depends on the application of the following criteria:
(a) relevance;
(b) necessity in assisting the trier of fact;
(c) the absence of any exclusionary rule;
(d) a properly qualified expert

*Evidence Act, R.S.O. 1990, c. E.23*

**Reports and evidence of practitioners**

**Definition**

52. (1) In this section,

“practitioner” means,

(a) a member of a College as defined in subsection 1 (1) of the Regulated Health Professions Act, 1991,

(b) a drugless practitioner registered under the Drugless Practitioners Act,

(c) a person licensed or registered to practise in another part of Canada under an Act that is similar to an Act referred to in clause (a) or (b). R.S.O. 1990, c. E.23, s. 52 (1); 1998, c. 18, Sched. G, s. 50.

**Medical reports**

(2) A report obtained by or prepared for a party to an action and signed by a practitioner and any other report of the practitioner that relates to the action are, with leave of the court and after at least ten days notice has been given to all other parties, admissible in evidence in the action. R.S.O. 1990, c. E.23, s. 52 (2).

**Entitlement**

(3) Unless otherwise ordered by the court, a party to an action is entitled, at the time that notice is given under subsection (2), to a copy of the report together with any other report of the practitioner that relates to the action. R.S.O. 1990, c. E.23, s. 52 (3).

**Report required**

(4) Except by leave of the judge presiding at the trial, a practitioner who signs a report with respect to a party shall not give evidence at the trial unless the report is given to all other parties in accordance with subsection (2). R.S.O. 1990, c. E.23, s. 52 (4).

1. (1) “health profession” means a health profession set out in Schedule 1; (“profession de la santé”)

SCHEDULE 1
SELF GOVERNING HEALTH PROFESSIONS

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Appendix C: Excerpts from Companion Document to: Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims, January 10, 2005

Cost and Prevalence of MVA-Related Impairments, Cost-Effectiveness of Intervention

Specifically with regard to motor vehicle accidents, large-scale survey data indicate that MVAs are the most frequently experienced traumatic event for males and the second most frequent for females (Kessler, et al., 1995), making them the single most common cause of Post-Traumatic Stress Disorder (PTSD) in the general population (Norris, 1992). As a result, lifetime prevalence estimates for PTSD following MVA are high. Large scale epidemiological data indicate that just over 11% of people who experience an MVA in their lifetime will develop PTSD (Breslau, et al., 1991; Norris, 1992). Among survivors of automobile accidents who are injured and require medical attention, 15-45% will develop PTSD within a year of the MVA (Blanchard & Hickling, 2004). A further 15-30% will develop post-traumatic stress symptoms that, although they do not meet full criteria for PTSD, are associated with significant distress and/or limitations in functioning (Green, et al., 1993; Hickling & Blanchard, 1992).

Although less studied than PTSD after an MVA, other impairments and conditions frequently occur and complicate the clinical picture for treatment. For example, travel anxiety has been noted in 11-28% of samples and is one of the most limiting and interfering psychosocial effects of MVA survivorship. Generalized anxiety disorder or chronic worry has been found in approximately 21%, and substance use disorders in approximately 17% of samples in MVA survivor research studies (Blanchard & Hickling, 2004). Increased irritability, hostility, and difficulty controlling anger are very common and have been identified as important factors in slowing treatment progress (Taylor, et al., 2001). Additionally, many of these symptom presentations co-occur. For example, PTSD often co-occurs with mood disorders (6-58% of research samples) (Blanchard & Hickling, 2004).
Finally, continuing pain and functional limitations/restrictions are frequent among MVA survivors, and often themselves lead to adjustment, mood and anxiety disorders with affective, cognitive, and/or physiological symptoms (Geisser, et al., 1996). Sexual disorders and difficulties achieving good quality sleep are often reported and exacerbate symptoms of pain, anxiety, depression, and anger, further impacting physical and emotional wellness. As these conditions affect clients’ abilities to function normally and participate fully in rehabilitative efforts, their persistence is associated with further functional limitations and participation restrictions. All of these are complicated further when the patient is also coping with a co-morbid traumatic brain injury and loss of cognitive function. The resulting loss of confidence and reduced self-esteem that can follow such situations often understandably become a specific focus of treatment in psychotherapy after a brain injury (Pepping & Prigatano, 2003).

Patients with both debilitating pain and post-traumatic psychological stress reactions to the motor vehicle accident present with very challenging and complex clinical situations (Beck and Coffey, in press). These patients typically have more impairments and more functional limitations than patients with other psychological diagnoses. The pain, physical functional limitations, and traumatic stress symptoms often potentiate each other making it necessary to address each of the impairments because of their interaction (Geisser, et al., 1996). Without appropriate psychological assessment and treatment, this group of accident victims is at high risk of chronic impairments and continuing disability. Horowitz (1986), in *Hospital and Community Psychiatry*, indicated that the longer a stress disorder continues, the longer it is likely to continue. As a result, treatment of this group of patients is often more intensive and requires longer duration than that for patients presenting with only chronic pain or post traumatic symptoms alone (Blanchard, et al., 2003).

Patient groups seen by psychologists following MVA include victims suffering with amputations, spinal cord injuries, or disfigurement, as well as family members grieving the traumatic death of a loved one. In these cases, psychologists are integral in helping the client adjust to their loss and go forward with their lives in this reality. Rehabilitation for the patient, and education and support for patients and families that includes neuropsychological services has demonstrated clinical utility and effectiveness in improving outcomes, reducing the economic burden associated with central nervous system injuries, and re-integrating patients into their homes and communities (Complair, Butler, & Lezack, 2003; Pepping & Prigatano, 2003; Ruff & Richards, 2003; Sherer & Novack, 2003; Wilson & Evans, 2003). For patients with brain injuries, neuropsychological assessment and rehabilitation is often essential in their treatment and rehabilitation. Neuropsychological assessments provide detailed information to ensure effective rehabilitation; cognitive rehabilitation enables patients and their families to understand the impact of the injuries and to develop compensatory strategies to regain function that is as normal as possible. Psychological education and therapy with the affected families is often critical to the rehabilitation process.

With regard to treatments of MVA-related conditions, such as chronic pain, economic evaluations show that increasing secondary prevention treatment for pain conditions results in decreased health care costs due to surgery and disability. For instance, Goosens and Evers (1997) reviewed 23 economic analysis studies and concluded that programs including psychological interventions aimed at improving pain management produced cost savings due to reduced absenteeism. Similarly, a recent study of the clinical, medical utilization, and cost outcomes associated with including psychological treatment in a multidisciplinary approach
to pain treatment found an 87% reduction in outpatient clinic visits in the first 3 months after treatment, resulting in a projected net annual saving of $78,960 in the first year alone. Psychological components were also associated with greater consumer satisfaction (Peters, et al., 2000). Building on this, a recent study of patient satisfaction and costs associated with multidisciplinary pain treatment found that patients consistently rated psychological and educational therapies higher on satisfaction measures than physical therapy and medical modalities; this was true both at post-treatment and at follow-up evaluations. These therapies were considered to be highly effective and helpful, at a relatively low cost (Chapman, Jamison, Sanders, Lyman, & Lynch, 2000). Similarly, Jacobs (1987, 1988) found that psychological services provided to chronic pain patients resulted in a $5 savings for each dollar spent on psychology. Thus, recent clinical studies have demonstrated the efficacy and cost benefits of including psychological services in interdisciplinary pain management programs (see Gardea & Gatchel, 2000 for a comprehensive review of this literature).

Including psychological treatment in treatment of pain is important to patients, to the ultimate efficacy of the intervention, and to the financial bottom line. It is reasonable to assume that similar overall savings would occur in the treatment of patients with pain disorders resulting from motor vehicle accidents.

Recent data also indicate that opportunities for similar offsets may exist when patients with PTSD resulting from automobile accidents receive psychological treatments. Initial data are consistent with the larger mental health literature indicating greater medical utilization among patients with this diagnosis. For instance, Deykin, et al. (2001) found that patients with higher medical utilization rates were almost twice as likely as low users (27.5% vs. 14.8%) to have PTSD. Both concurrent depression and physician-diagnosed physical conditions were found to add to the prediction of medical utilization among PTSD-diagnosed adults. The authors concluded, “PTSD, alone and in combination with depression, has a direct negative relationship with physical health that, in turn, is associated with more frequent use of primary health care services”. Similarly, Walker, et al (2003) found that compared with women who had few post-traumatic stress symptoms, those with a moderate number of symptoms had 38% greater annual costs, and those with the greatest number of symptoms had 104% greater costs, even after adjusting for depression, chronic medical disease, and demographic factors. The authors concluded that “these findings are similar to those found in studies of costs related to major depression and suggest that instituting health services interventions to improve recognition and treatment of PTSD in primary and specialty care clinics may be a cost-effective approach for lowering the prevalence of this disorder”.

Recent North American data specific to MVA survivors are consistent with this, and indicate that the direct and indirect costs of psychological impairments, such as PTSD and depression are substantial. MVA victims who have PTSD are more distressed and impaired in their usual functioning (performance at work/school/homemaking, relationships with family or friends) than MVA survivors who do not have PTSD (Blanchard, Hickling, Taylor, & Loos, 1995). And, MVA survivors with concurrent depression and PTSD fare even worse, as they are more subjectively distressed and impaired in their usual functioning, with symptoms that are slower to remit than those with PTSD alone (Blanchard, Buckley, Hickling, & Taylor, 1998). In total, Blanchard and Hickling (2004) found that even in a sample of MVA survivors who were not seeking psychological treatment, those with PTSD were more impaired than either those with subsyndromal symptom presentations, or controls, in all areas of functioning assessed. The authors concluded, “it is clear that meeting the criteria for PTSD subsequent to an MVA usually implies a major impact on the individual’s life” (p. 92). Individuals with
such impairments are transformed from being contributors and drivers in a thriving economy, to being a drain on its resources.

Emerging data on the costs of MVA-related psychological impairments are consistent with these results and those of non-MVA health insurance data indicating high costs associated with failing to treat impairments, such as PTSD. An Australian study found that the total health and economic cost in Australian dollars for a sample of 391 motor vehicle accident victims was A$6,369,519.52. Using self-report data, the authors found that 31% of the sample were depressed, 62% were anxious, and 29% met criteria for PTSD nine months after their respective accidents. Of particular relevance to any attempts to find costs savings is the following: PTSD cases incurred significantly higher health care costs compared with non-PTSD cases, and untreated PTSD cases incurred the highest costs of all. These results were considered statistically and economically significant. The authors concluded that, “the health and economic costs associated with motor vehicle accidents are enormous. Psychiatric morbidity among victims was high, and motor vehicle accident-related PTSD significantly contributed to increased overall health care and economic costs.” (Chan, Medicine, Air, & McFarlane, 2003). In keeping with this, preliminary data indicate that this utilization decreases following targeted, clinically effective psychological intervention (Grunfeld, et al., 2003).

**Appendix D: WSIB 3-Step Clinical Screening Guide**

Dear Health Care Professional:

**Re: 3-Step Clinical Screening Guide**

During the development of Programs of Care (POC), the Fee-setting Advisory Committee recognized that from time to time, regardless of the nature of the injury, injured workers may show evidence of non-physical symptoms. These non-physical symptoms may indicate a psychological or emotional impairment that would be a barrier to POC participation and recovery. This can be an issue for all Programs of Care.

The Ontario Psychological Association (OPA) has prepared a 3-Step Clinical Screening Guide to assist health care professionals treating injured workers, when these situations arise, in determining whether a referral may be appropriate. The use of this guide is not mandatory. It is intended only to assist health care professionals who may wish to use it to exercise their professional responsibility and judgment. As regulated health professionals, health care providers are responsible to their regulatory colleges for the standard of clinical care they provide, including referral decisions. This is the case whether or not a tool such as this guide is used. The use or non-use of this guide does not alter each health care provider’s professional responsibilities as determined by their professional college regulations and legislation.

Yours sincerely,
Health Professional/WSIB Fee-setting Advisory Committee

Dr. Ruth Berman, Ontario Psychological Association
Don Gracey, Ontario Physiotherapy Association
Dr. Robert Haig, Ontario Chiropractic Association
Karen MacKenzie-Stepner, Ontario Association of Speech-Language Pathologists and Audiologists
Teresa Riverso, Ontario Society of Occupational Therapists
Donna Bain, Workplace Safety & Insurance Board

The 3-Step Clinical Screening Guide will assist health care providers to determine whether referral for consultation is indicated for non-physical symptoms that may be a barrier to Program of Care participation and recovery.

This screening process requires that the combination of your observations of the patient (Step 1) and patient responses to the questions (Step 2) will assist you to determine whether to recommend a referral to the patient (Step 3).

1. **Professional observations:**
   Notable differences in client behaviour, appearance, demeanour suggestive of sad feelings, depressed mood, low energy, hopelessness, poor self-care; or persistent worry, tension, stress; or pain focus, difficulty maintaining engagement in treatment; or lack of anticipated response to treatment.

2. **Specific questions:**
   
   A. In the past couple of days, have you...
      1. lost interest in enjoyable or important activities?
      2. lost confidence in yourself?
      3. felt hopeless?
      4. had low energy?
   
      **2 or more**
   
   and/or
   
   B. 1. felt keyed up, on edge?
      2. been worrying a lot?
      3. been irritable?
      4. had difficulty relaxing?
   
      **2 or more**
   
   and/or
   
   C. 1. had an episode of extreme fear or discomfort?
      2. experienced a "reliving" of a frightening event including nightmares and flashbacks or thoughts about it just popping into your head?
      3. avoided things that remind you of a frightening event?
   
      **2 or more**
3. **Client agreement: willingness / interest in a referral for consultation to determine need for assessment and possible treatment.**

When treating a worker in a Program of Care and the worker has given consent to the collection of this information; and the results of the 3-Step Clinical Screening Process lead you to recommend a referral because non-physical symptoms may be a barrier, WSIB should be advised of the worker's acceptance or rejection of the referral.

**Appendix E: Medical assessment costs 'frightening' insurers TheStar.com - Business - July 05, 2008, James Daw**

Medical assessments are gobbling more of your auto insurance premiums. So insurers point to the cost as an enemy of stable premium rates in Ontario, while lawyers see a possible source of funds for innocent accident victims. The assessment cost is not large in proportion to the $8.1 billion in premiums Ontario motorists paid last year, but it has risen rapidly from $201 million in 2004 to $313 million last year.

"If our goal is to control costs, we have to ask why," says Don Forgeron, Ontario vice-president of the Insurance Bureau of Canada, who supplied the figures. The cost of assessments is about 60 per cent of what insurers spent on treatments, points out Robin Spencer, president of Aviva Canada Inc. "That is a frightening figure," he says. Aviva is the largest insurer of private autos in Ontario, which has the highest average premiums in Canada. The company is trying to improve public perceptions of insurers with a funny, self-deprecating advertising campaign and a service guarantee that includes a refund of premiums.

Regulators permitted Aviva subsidiary Traders General Insurance Co. to raise its premium rates an average of 4.1 per cent and Pilot Insurance Co. 3.2 per cent in the first quarter of this year. Aviva Insurance Co. of Canada cut rates slightly. Aviva managed to increase profits last year and again in the first quarter of this year. But Spencer said much of the $335 million earned last year came from selling its entire holding of stocks and switching to bonds with later maturity dates, as well as from lines of business other than Ontario auto insurance.

Toronto lawyer Richard Halpern, chair of the Ontario Bar Association's auto insurance reform group, agrees with insurers that "assessments are a gargantuan drain in the insurance system." "We need to pare down accident benefits and bring back fair and equitable treatment for innocent accident victims (by reducing the mandatory deductions from court awards)," he says.

Insurers must pay for a medical assessment before they can deny or cut off a benefit for income replacement, physical rehabilitation, housekeeping expenses, home renovation or other benefits. They must also pay for assessments the injured person may arrange to
contest the denial of benefits. This system of duelling assessments replaced the former system of independent Designated Assessment Centres in 2004. It is one of many items up for discussion in a five-year review of the highly regulated auto insurance product. Insurers are sensitive to rising costs after crossing the line from profitability to merely breaking even on Ontario autos last year, according to Julie Dixon, federal Superintendent of Financial Institutions. Insurers are limiting price increases to hold their market share, but Spencer says they should be free to raise rates when they see fit. Last month, the Ontario government posted on websites a call for public comment as part of the five-year review of auto insurance. Submissions regarding issues of affordability and availability, consumer protection, accident benefits, dispute resolution, fairness and efficiency are due by July 14.

What is disappointing – even shocking – is that the public will not get to search government websites to learn what lobbyists are saying. Consumers will have to apply under the cumbersome Freedom of Information and Protection of Privacy Act.

James Daw, CFP, appears Tuesday, Thursday and Saturday. He can be reached at Business, 1 Yonge St., Toronto M5E 1E6; at 416-945-8633; 416-865-3630 by fax; or at jdaw@thestar.ca by email.

Appendix F: Excerpts from: Companion Document to: Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims, January 10, 2005

Kubiszyn, et al. suggest that psychological assessment has demonstrated validity and utility “for several clinical health care applications… [including] the a) description of clinical symptomatology and differential diagnosis; b) description and prediction of functional behavior; c) prediction of health outcomes; d) prediction of health care utilization; e) prediction of psychotherapy, forensic, and mental health outcomes; f) identification of patient/claimant/client characteristics that affect treatment; and g) use of psychological assessment as treatment in itself” (p. 120). In fact, diagnostic tests performed by psychologists are state-of-the-art tools. Meta-analytic research on assessment validity indicates that many psychological tests detect pathology at a rate indistinguishable from those of medical tests. For example, psychological tests detect dementia, depression, or psychotic disorders just as accurately as medical tests such as pap smears, mammography, magnetic resonance imaging (MRI), and electrocardiograms detect medical pathology. Moreover, some psychological tests work just as well as medical tests to detect the same outcome. For instance, the ability to detect dementia is as good with neuropsychological tests as it is with MRI (Daw, 2001). Increasingly, physicians and other health care professionals turn to psychologists for their diagnostic capabilities. These diagnostic services detect functional impairment and assess the prognosis for improvement or deterioration in functioning. Psychologists apply these results and develop treatment and rehabilitative services.

Performing a proper clinical diagnostic investigation also is an investment in a procedure that ensures that efficient, effective treatment is provided often leading to reduced disability costs.
It provides benefits to the client by meeting the need for appropriate treatment, it benefits the clinician by ensuring that treatment time can be targeted and efficient, and it provides a financial benefit to the system by ensuring that all impairments are captured and treated in the most efficient manner. It also provides benefit to all stakeholders as an accurate and comprehensive communication tool that can be used in avoiding disputes over benefits.