Ontario Society of Occupational Therapists

July 14, 2008

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RE: FIVE YEAR REVIEW OF STATUTORY ACCIDENT BENEFITS SCHEDULE

Dear Mr. Handler,

On behalf of occupational therapists working in the auto insurance sector in Ontario, the Ontario Society of Occupational Therapists (OSOT) appreciates the opportunity to provide our feedback to the 5 Year Review of the Statutory Accident Benefits Schedule (the SABS). We understand the Government's mandate to ensure both affordability and availability of the insurance product, while at the same time preserving a strong Accident Benefits program to restore injured persons to their healthy pre-accident lifestyle.

Occupational Therapists play a valuable role in returning injured persons to their prior occupations, whether these are at home, at work, at school or in the community at large. Occupational performance is the domain of occupational therapy. This focus informs our comments to this review and drives many of our recommendations. It should not go unnoticed that the philosophical and theoretical underpinnings of occupational therapy lend an informed and congruent perspective to the government's goal: to assure that our auto insurance system balances a capacity to restore injured persons to their healthy pre-accident lifestyle with the delivery of a compensation system that fairly supports claimants when their injuries legitimately preclude their ability to function and earn a living.

Our members' feedback to this consultation has been largely framed in two significant themes. First, we advocate for respectful and thoughtful attention to the experience of the claimant in the system. The experience of the claimant shapes their relationship with the system, their insurer, their health care provider

and dynamically affects their engagement and commitment to the goals of recovery and return to work and function. Too often we hear of clients whose experiences are ill-informed, frustratingly slow and repetitive, or frankly adversarial. None of these scenarios bodes well for successful and streamlined recovery post injury. We need to build a system that engages the claimant expediently and positively in their rehabilitation/return to function journey. We would suggest that this focus works in all stakeholders' best interest.

Secondly, we advocate for continued refinement of the system to truly enable a focus on functional restoration after injury in a motor vehicle accident. This speaks to a focus on assessment and treatment which efficiently and effectively supports claimant's engagement in recovery. This also speaks to an efficient means of compensation which expediently provides benefit support, thereby enabling the claimant to attend to the business of rehabilitation without financial stressors.

Feedback from our members has been sought in two ways.

In June 2008, the Coalition Representing Health Professionals in Automobile Insurance (of which OSOT is a member) conducted a survey of member practitioners working in the sector. Data collected from the 749 health care provider respondents has informed our perspectives and recommendations. Of these providers, 40% were involved at some level providing Insurer Examinations, and 60% were strictly treatment providers. One hundred and forty-three (143) respondents were Occupational Therapists. The results from this survey will be shared throughout this submission.

Additionally, the Society's Auto Insurance Sector Team plays an active role in the ongoing monitoring and addressing of member concerns relating to practice in the sector. This consultation provides opportunity for the Society to share the experiences and insights of frontline occupational therapists that work with clients injured in motor vehicle accidents. There are over 580 occupational therapists registered with the College of Occupational Therapists of Ontario that indicate their work is funded by auto insurers. We believe that OTs have valuable insights to lend to this sectoral review.

Ontario's auto insurance system is both robust and complex. In the context of this 5 year review of the SABS, OSOT is thoughtful that changes in any one component of the system may well impose consequences on other components. This speaks to an incentive to address changes that truly balance issues of affordability and availability of insurance product with issues relating to the quality and integrity of the delivery of client-focused accident benefits that promote functional restoration and occupational performance. In general, occupational therapists see the current system of auto insurance benefit delivery to be working fairly effectively. That said, however, members identify areas where attention to potential for change could improve, streamline and reduce costs within the

system. We offer our comments on the following key issues to facilitate the process of building a better auto insurance system in Ontario. Please note that we have listed our recommendations as an appendix to this document.

1. THE CLAIMS APPLICATION PACKAGE

The Claims Application Package consists of:

1. OCF-1, which provides general information about the accident and the claimant to the insurer
2. OCF-2, Employer's confirmation of income to be signed by the Employer
3. OCF-3, Disability Certificate, to be completed by the health care practitioner, often the family doctor
4. OCF-5, Disclosure of Health Information
5. OCF-18, Treatment Plan
6. OCF-23, PAF

Under Section 32 (2), the insurer has an obligation to provide *"information to assist the person in applying for benefits"*.

Identified Problems

Notwithstanding the obligation that insurers provide information to facilitate the application for benefits process, claimants struggle to complete this package. Many turn to representatives (lawyers, paralegals) to aid in understanding and completing the forms.

Front line health care providers find that claimants (or their family members) often rely on them to assist in completing the Claims package due to its complexity, the claimant's ill health (due to injury) and/or claimant's lack of facility with the English language. When claimants are unable to complete the OCF-2 and OCF-3 in a timely manner, the result is a delay in accessing benefits. Delays can occur simply because the claimant is unable to visit their employer or physician because of the limitations of their injury or, because the family physician may be booked weeks in advance; employer on vacation, etc. Without a fully completed Application package, the insurer does not have to respond to Assessment Proposals or Treatment Plans (OCF-22s and 18s) as per Section 32 (5), which leads to unnecessary delays in treatment.

These kinds of delays were reported in an astounding 62% of respondents to the Coalition survey question related to the Claims Application package identified concerns relating to claimant ability to complete the package.

- 42.8% indicate that they are *sometimes* asked to assist claimants to complete the package
- 18.9% said they are *always* asked to assist the claimant

- 62% said that treatment is either *always or sometimes* delayed because the package has not yet been completed and submitted to the insurer.

Proposed Solutions

i) Simplify the Claims Application Forms both in language and structure (e.g. claimants are required to repeatedly document their name and address) to facilitate claimant's capacity to complete them independently in a timely manner.

ii) Modify the application requirements to enable adjusters to contemplate an OCF-22 to commence assessment and ultimately treatment upon receipt of the OCF-1 alone (assumes OCF-2 and OCF-3 would follow within a defined period of time).

iii) Explore the potential to engage a public "help-line", through FSCO or each insurance company, to assist individuals who are encountering difficulty completing the Forms. Ideally, this help-line service should be offered in a number of languages. Such a resource would provide a complimentary alternative to seeking representation to assist claimants with the application process.

We must be mindful that the claimant's initial experience with the claims process starts with the forms. This sets the tone for the remainder of the claims experience. It is important that the application forms are 'user friendly' to avoid frustration such that claimants can focus on early functional recovery.

2. NUMBERS OF ASSESSMENTS

The SABS establishes a number of assessments conducted for various purposes:

Who	Purpose of Assessment	Section
Treating Health Practitioner	To determine type, amount and duration of treatment. Assessment must precede treatment, as per Regulatory bodies	24
	To determine the need for benefits such as attendant care, housekeeping and home maintenance, caregiver and non-earner	24
Insurer	To determine if medical/rehabilitation benefit entitlement is "reasonable and necessary"	42
	A) In-person examination	
	B) Paper review	
Insurer	To determine entitlement to one or more specified benefits	42

Treatment team or Insurer-selected team	To determine Catastrophic entitlement	24 or 42
Treating Health Practitioner	Rebuttal Examinations	42.1
	A) In-person examination	
	B) Paper only	

Identified Problems

a) We understand from insurers that a major concern is the rising costs of assessments in the system in spite of the elimination of DAC assessments in March 2006. It is not known to OSOT what percentage of assessment costs are related to Section 24 and whether there has been an equally significant increase in assessment costs under Section 42.

b) We also understand that there are a number of clinics/practitioners who submit several OCF-22s at one time, many of which are inappropriate given either the diagnosis and/or the stage of recovery.

c) The OCF-22 was contemplated with the expectation that the proposing health care practitioner would complete the form by contacting the client and, at the same time, obtain their informed consent. It has been the practice of some practitioners, however, to assign this task to administrative staff. This has the potential to increase the number of OCF-22's.

d) Claimants complain about being over-assessed and may claim they didn't know about all the assessments they were to have.

e) Occupational therapists find it interesting that some health care professionals routinely request two or three in-home assessments to determine benefit needs, *individually*, such as Attendant Care, Housekeeping/Home Maintenance, Equipment provision, Caregiving Benefit, etc... OTs routinely perform **one** assessment to address all of these benefits at one time, unless restricted by the claimant's status or availability. We consider this to be 'best practice' when working in the community, and the most cost-effective method for the insurer.

Proposed Solutions

Occupational Therapists are supportive of streamlining assessments because ultimately the increasing costs of assessments reduce the claimant's funding available for benefits. At the same time, it is necessary to protect claimant access to assessment, benefits and treatment. Consequently, while it is important to prevent excessive or fraudulent activity of a few persons, it is also

necessary to protect access for the majority. As such, our members endorse the following:

i) Establish provisions that ensure that the claimant's informed consent is obtained by the health practitioner who signed the OCF-22.

ii) Establish provisions that ensure that the claimant is made aware that an OCF-22 has been submitted on their behalf by making it mandatory for the claimant to be provided a copy of the OCF-22.

iii) We understand that the new billing and forms submission process through Health Claims in Auto Insurance (HCAI) will produce data which will facilitate identification of questionable patterns of providers and clinics. We would be supportive of Insurers' investment into mechanisms for monitoring and investigating questionable practice patterns.

iv) While occupational therapists are willing to partner with Insurers to find solutions and strategies to minimize the imposition of assessment on the claimant and the system, it is important for insurers to reflect on their own practice with respect to the number of Insurer Examinations requested. HCAI will be instrumental around highlighting patterns of OCF-22 denials and the requests of Insurer Examinations.

v) Occupational Therapists are best positioned to undertake benefit entitlement assessments given our functional expertise and the ability to assess several benefits at one time. It would seem reasonable to assume that such practice could be a system best practice.

3. TIMELINES FOR INSURER RESPONSE

The following tables provide an overview of the timelines to be met by both the Insurer and the Insurer Examiners in relation to processing and approving assessments and treatment plans. It would appear that while the Examiners (health practitioners) have been able to meet these timelines, insurers are encountering some difficulties.

Timelines for the insurer to address an OCF-22/Request for an Examination or Assessment	
Insurer to notify practitioner	3 business days (days are counted starting on the day **after** the OCF-22 is faxed to the insurer); if timeline is missed, assessment is deemed approved
Insurer and insured to get materials to the IE paper reviewer	5 business days
I.E. Paper Reviewer to review materials and prepare a report	5 business days
Insurer to get the report to claimant	5 business days
TOTAL	**18 business days or 3.5 weeks**

When health care providers were asked about the timelines surrounding OCF-22s, out of 598 respondents, 91% indicated a preference that the timeline remain unchanged or shortened.

When we asked health care providers if insurers are able to respond to their OCF-22s within the prescribed 3 business days:

- 14.1% of respondents indicated “always”
- 62.4% of respondents indicated “sometimes”
- 23.5% of respondents indicated “rarely or never”.

Identified Problem

It is our understanding that Insurers find the initial 3-day time limit too restrictive and would like to see this extended. During the development of the pre-approval system and the concept of the OCF-22, health care providers had assurance from insurers that they could meet a swift turn-around time to ensure expeditious assessment and treatment.

Proposed Solution

Feedback from health care providers indicates a preference for this timeline to remain unchanged. Anticipating the return of HCAI and electronic submission, we continue to endorse 3 business days for insurers to respond to the OCF-22 as we believe the promises of HCAI are to streamline processes for adjusters to process claims.

Timelines for the insurer to address a Treatment Plan	
Insurer to notify claimant of either approval or denial of T.P.	10 business days
Time to arrange the assessment	5-10 business days
Time for the IE examiner to prepare the report	10 business days
Time for the insurer to review the report and send it to the insured	5 business days
TOTAL	**35 business days or 7 calendar weeks**

Identified Problem
It is not uncommon for insurers to wait until the very last day to deny a treatment plan. This unnecessarily protracts the period in which the claimant must wait for his/her treatment. Overall, the claimant can wait a total of 7 weeks to receive his/her determination regarding treatment if the entire process is completed in the maximum time permitted. In many cases, this is far too long to wait for treatment which has its greatest value early post-injury.

Proposed Solution
We propose two solutions in relation to this Identified Problem:

i) pay for up to a maximum of 50% of the proposed therapy services only (e.g., services such as massage, physiotherapy, occupational therapy, chiropractic etc.) pending the final determination; this would encourage insurers to move swiftly through the determination process while allowing patients necessary treatment and/or

ii) shorten the period from 10 business days to 5 business days, in which the insurer has to respond to a treatment plan.

4. ATTENDANT CARE BENEFITS – WHO CAN COMPLETE THE FORM 1

The attendant care benefit pays for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant or services provided by a long-term care facility, including a nursing home, home for the aged or chronic care hospital. The monthly amount payable by the attendant care benefit is determined in accordance with Form 1. An application for attendant care benefits for an insured person must be in the form of an assessment of attendant care needs for the insured person that is prepared and submitted to the insurer by a member of a health profession who is authorized by law to treat the person's impairment.

Identified Problems

Insurers and occupational therapists have noted a disturbing increase in the numbers of Form 1s being submitted and the related cost of both the Assessments themselves, and the benefit arising out of the Assessments. Often, these assessments are completed by practitioners who do not demonstrate specific or adequate training in functional assessments and treatment (including assistive devices, activity adaptation, home modifications) to address the functional impairment resulting from a physical, cognitive/ behavioural and/or psychosocial impairment. Consequently, excessive attendant care benefits are being arbitrarily awarded to claimants without objective foundation resulting in excessive cost exposure to insurers. Insurers must respond by ordering Insurer Examinations which, then, can trigger a rebuttal. Overall, a single poorly executed attendant care assessment often results in significant and unnecessary costs to the system and the burden of attending multiple assessments to the claimant.

Proposed Solutions

i) Much like the WSIB's system, OSOT proposes that only those health practitioners who are skilled in performing attendant care assessments be permitted to complete the Form 1, specifically occupational therapists[1] and nurses.

Occupational Therapists are regulated health care professionals whose scope of practice is focused on occupational performance – the client's ability to function. Their education and mandatory clinical training and experience within affiliated acute, long-term and rehabilitation hospital settings as per their professional school curriculum, prepare them to comprehensively assess and provide treatment that focuses an individual's capacity to perform day to day occupational tasks. This is, of course, the focus of an attendant care assessment.

Other practitioners who are currently listed on the Form 1 should be removed. In cases where other health care practitioners recognize a need for attendant care for their patient, they can refer to either an occupational therapist or nurse to complete the Form 1 much the same way physicians refer to the appropriate specialist. This will decrease the number of unnecessary, inappropriate and inaccurate assessments, and avoid unnecessary exposure and limit assessment costs to the insurer.

[1] **Occupational Therapy Scope of Practice, Occupational Therapy Act, 1991**
The practice of occupational therapy is the assessment of function and adaptive behaviours and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure.

While it may be argued that many practitioners are able to assess physical dysfunction, the completion of the Form 1 is multi-factorial as there may be a combination of physical, cognitive/perceptual, behavioral and psychosocial factors impeding functional independence. Occupational therapists are trained, not only in the identification of these impairments, but are able to determine how these impairments impact functional performance. Moreover, occupational therapists possess the training and skill sets necessary to remediate dysfunction through training or re-training of skills, the introduction of assistive devices, the modification of the task or environment, supporting and counseling of clients and their families, etc.

OSOT asserts that the effective assessment of attendant care needs requires not only the capacity to assess what a client can or cannot do, but also the skills to determine, based on assessment, what potential the client has to re-assume skills they need for their job of living and what supports are required to achieve this potential – treatment, equipment, benefit support, etc. Occupational therapists who complete Attendant Care assessments are simultaneously identifying appropriate aids/devices, adaptations, modifications and/or treatment modalities that will increase the injured person's level of independence and in turn decrease their need for attendant care support. This reduces long range costs to the insurer and the system.

The capacity to manage functional skills draws upon not only the client's physical capacity but also their mental health and stamina, cognitive and perceptual abilities as well as the environmental context in which they live or work, including availability of support. Assessment of Attendant Care Benefits must provide a wholistic assessment of these complex components. Professions that have training and expertise in both the management of physical injury and impairment and mental health, cognition and social behaviours have the most to offer these complex assessments. OTs and nurses have such expertise.

Occupational therapists have taken a leadership role in the area of assessment of attendant care needs in Ontario's auto insurance system. In 2001 and, again, in 2008, the Ontario Society of Occupational Therapists developed two papers for their members which provide reflective practice tools to foster excellence in the assessment and determinations required to complete the Assessment of Attendant Care Needs, Form 1. These tools facilitate a uniform and comprehensive approach to assessment and promote understanding of the process and benefit in relation to the SABS.

ii) Insurers and all regulated health professionals should take advantage of existing mechanisms to challenge the competence of Form 1 assessors by utilizing regulatory college complaints mechanisms.

5. ATTENDANT CARE – RETROSPECTIVE BENEFITS

Currently, the SABS stipulates that claimants cannot access attendant care benefits retroactively. Insurers can deny a claim for this benefit retroactively.

Identified Problems

a) Claimants are not always aware of their entitlement to the attendant care benefit because they have not been informed by their insurer.

b) There may be a period during which the insured is unaware that they can make a claim through their own auto insurance policy (e.g., snowmobile accidents) or via the policy of the insured who struck them (e.g., pedestrian, cycling cases). Thus, several months might pass before the claim is made. The claimant should be able to reimburse their attendant(s) for time already spent in caring for the injured individual priot to submission of a formal claim.

Proposed Solution

i) Introduce wording in the SABS that permits claimants access to attendant care benefits retroactively.

6. IN-HOME ASSESSMENTS

The term “in-home assessment” is not found within the SABS but ironically has become a term used widely in the auto insurance sector as if it were a unique assessment or procedure under the SABS. An in-home assessment is simply an assessment completed inside a person’s home for the purposes of determining a claimant’s need for treatment (medical benefits), rehabilitation benefits (home, workplace or vehicle modifications) or other benefits (housekeeping/home maintenance, attendant care, caregiving, etc). Not all assessments for these purposes have to be completed in the client’s home but when the benefit assessment is related to how the client functions in the home and community (or workplace), it is best to assess in the context in which the client must function.

Occupational therapists are most often in the position of assessing a client in their home because the nature of their treatment which focuses on occupational performance, the ability to manage day to day life skills (e.g., self care, work, leisure), is most realistically assessed in the environment where the client must manage. For example, it is impossible to accurately assess a client’s ability to

safely manage daily hygiene, toileting and bathing skills anywhere but in the particular bathroom in which the client needs to function. Additionally, OTs are frequently the assessors of a client's need for (or eligibility for, when acting on the insurer's behalf) benefits such as housekeeping/home maintenance or attendant care which are related to how independently the client is able to manage in their home.

It is clear that the costs of providing an assessment in a client's home are typically higher than the costs of clinic-based assessments. Health practitioners are compensated for their travel to and from the client's home. It is reasonable to assume that "in-home" assessments should only be completed when it is the *best* environment for which to assess the medical benefit *or* the assessment is to establish need/eligibility for a benefit that is directly related to how a client functions in the home/community.

Identified Problems

a) OSOT understands that insurers are concerned about the increasing volume of assessment costs. In-home assessments may be a particular target because they incur additional expenses (travel) for the insurer. OSOT is not privy to insurer data that would substantiate whether costs of providing assessments in clients' homes is increasing disproportionately to other assessments.

b) Insurers report, and occupational therapists have observed, an increasing trend of in- home assessments completed by professionals whose scope of practice related to the medical benefit they provide is typically not focused on functional performance of daily living skills in the home/community. It is unclear why such professionals would need to assess clients in their home unless they are assessing the client's need for benefits related to their ability to function in the home. When insurers see such assessments completed by providers whose education and scope of practice does not include these specific functional assessments, this triggers the insurer to respond by requesting an Insurer Examination….. and so the cycle begins and the costs escalate.

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Proposed Solutions

i) OSOT positions that occupational therapy assessments for the purposes of developing a treatment plan for OT services that are focused on assisting the client to improve their occupational performance and independence in the home, work and community environments are best completed in the client's home where the environmental context in which the client must perform their day to day living skills are best completed in the "in-home" environment.

As outlined in the College of Occupational Therapists of Ontario website section entitled, "What is an Occupational Therapist"; "Occupational therapists are health care professionals who assist an individual in developing or maintaining life roles and activities at home and in the community when one's ability to function independently has been challenged by accident, handicap, emotional Identified Problems, developmental difficulties or disease… Interventions may include the training of daily living activity and community life skills; prescription of specialized equipment; evaluation and modification of home, work or school environments; and related education and counseling."

ii) OSOT asserts that the occupational therapy scope of practice is perfectly suited to assess the client's self- care and housekeeping/ home maintenance responsibilities within his/ her home and provide expert insight to the insurer regarding the client's needs for attendant care, housekeeping, etc. In fact, we position that occupational therapists are the *best* choice of professional to perform such assessments and provide expert validation of benefit need to the insurer.

iii) The additional costs of providing an assessment in a home environment should be offset by the advantage that insight into the home dynamic brings to the assessment and subsequent recommendations. Good assessments give insurers *accurate* information about needs for home modifications, attendant care, housekeeping needs, etc. We believe that, when qualified professionals are completing assessments in the home, the insurer gets a valuable return on the investment in travel costs.

This notwithstanding, OSOT is supportive of efforts to limit unreasonable costs related to in-home assessments. We would position that it is a professional "best practice" for OTs to complete a comprehensive assessment when in the client's home that provides opportunity to make recommendations for multiple benefits further to the same one assessment. In other words, we would suggest that it should be the exception to the rule that separate "in-home" assessments be completed for attendant care, housekeeping/home maintenance, treatment plan, etc. We would position that this cannot be a regulated expectation because client variables will affect the capacity to complete everything in one assessment. Such variables might include; client's tolerance, availability of family members, complexity of injury, client's mental or cognitive status. This notwithstanding, we believe that if insurers are seeing patterns of multiple assessments for each benefit, this might serve as a red flag for investigation.

iv) OSOT and other professional associations have advocated for insurers to make use of existing complaint mechanisms for regulated health professionals to address concerns they may have with the practice of any professional providing services to their claimants. We lend emphasis to this problem solving option later in this document.

v) OSOT is prepared to work further in consultation with insurers, FSCO and occupational therapists if warranted to generate solutions to problems identified with "in-home" assessments.

7. PRE-APPROVED FRAMEWORKS (PAF)

Occupational Therapists were happy to participate in the latest reform with respect to the WAD I and II Pre-Approved Frameworks (PAFs). The PAF reform combined these two diagnoses into one PAF, extended the timeline for entry into the PAF, prepared an algorithm for addressing treatment inside the PAF and promoted a functional restorative approach to management of WAD injuries.

Identified Problem
Notwithstanding the recent revisions to the PAF, we do not feel that approach to treatment of WAD has changed significantly.

Proposed Solutions
We reference the new evidence made available form the recently published research of a ten year retrospective study, (Spine, February 2008, *Bone and Joint Decade 2000 to 2010 Task Force on Neck Pain and Its Associated Disorders*) which identified that no active treatments were clearly superior in the short- or long-term, and interventions that focused on regaining function and returning to work as soon as possible were relatively more effective. We believe this work gives strength to the intended functional restorative approach and early return to work foci of the new PAF. We believe that occupational therapists should be more integrally involved in the PAF. This may require our Society to reach out to clinics in an educative manner to address the valuable role Occupational Therapists can play in the area of neck pain.

Timelines for PAFS (S. 38 (8) 2.)

Timelines for the insurer to address an OCF-18 that might be a PAF	
Insurer to notify practitioner	5 business days (if this timeline is missed, then the insurer CANNOT take the position that the Treatment belongs in a PAF)
Insurer and insured to get materials to the IE paper reviewer	5 business days
I.E. Paper Reviewer to review materials and prepare a report	5 business days
Insurer to get the report to claimant	5 business days
TOTAL	**20 business days or 4 weeks**

Identified Problem
There is a perception of insurers that persons who belong in the PAF may not be entering the PAF for WAD I and II injuries.

Proposed Solutions

I) The insurer has the ability to utilize the Section 42 paper review process to address these disputes (e.g. to answer the question regarding the claimant's suitability for the PAF). The timeline for an insurer to deliberate on this issue is 5 business days which we feel is sufficient to consider and act upon a Treatment Plan. The data that will eventually arise out of HCAI will inform us as to how often insurers are challenging treatment plans.

ii) More importantly, however, it may be beneficial to review the course of PAF patients to see if these patients are being treated in accordance with what the evidence shows in terms of best outcomes, and to follow their progress with respect to the length of treatment and the incidence of neck pain after treatment has concluded.

8. REBUTTALS

Rebuttals were intended to provide some balance to the system. The rebuttal provides claimants with an opportunity to address perceived errors in the Insurer Examination and equips them with their own opinions prior to and during mediation or arbitration. The rebuttal is also useful in educating adjusters about the weaknesses of the Insurer Examinations upon which they are relying both regarding clinical facts of the patient situation, standards of the profession, and appropriate interpretation of the SABS.

The SABS has imposed **limitations** both in **frequency and cost** with respect to the rebuttals**.** In contrast, there are no limitations outlined with respect to the frequency and costs of assessments requested by insurers given the wording under S. 42 which says, *"as often as is reasonably necessary."*

Identified Problem
Feedback from our members indicates that providers are somewhat frustrated with the rebuttals as they perceive that their input via the rebuttal does not seem to change the outcome for the client, at least in the short term.

Proposed Solutions

i) OSOT strongly supports the use of rebuttals as a means for the claimant to have more information in response to the Insurer's Examination findings and evidence in preparation for mediation or arbitration; otherwise, the insured may be attending with less current and relevant information regarding their medical and functional status.

ii) Rebuttals should be permitted in cases of OCF-22 denials in relation to catastrophic files only.

iii) Insurer examiners should be strongly encouraged to communicate with the original treatment provider during either a paper review or insurer examination. This may require changes to Section 24.1 to include this communication during an OCF-22 paper review. As well, the appropriate consent for this communication to take place should be included on the respective forms to prevent delays and enable assessors to meet the prescribed timelines for examinations and assessments.

iv) Once the insurer receives a rebuttal report, it should be deemed 'best practice' for the Insurer to request a response from the Insurer Examiner and this response should then be provided to the treatment practitioner who completed the rebuttal report. We believe that a Superintendant's Guideline identifying best practices or expectations of insurers would be of value.

v) Rebuttals have a fixed cost which was set in March 2006. These fixed costs should be increased annually to reflect the cost of living adjustment.

9. HEALTH PROFESSIONAL EXPERIENCE IN THE INDUSTRY

In order to ensure efficacy and keep costs low in the auto sector system, it is essential that both insurers and claimants have confidence in the opinions and

recommendations being set forth by clinicians. Occupational therapists are sought out to provide their opinions and recommendations in terms of both s.24 and s.42 assessments in order to facilitate a claimant's rehabilitation and/or to help the insurer determine if a claimant is eligible for a benefit(s). For a health professional's opinion to be accepted with confidence, it is essential that the professional have both clinical experience and knowledge. The Unfair and Deceptive Acts and Practices sets an expectation with respect to the level of experience and expertise of an Insurer Examiner but without definitive criteria.

Identified Problem
As a result of the restraints imposed by the Professional Services Guideline as well as the increasingly litigious and combative/competitive practice environment, and insurer pressures to offer flat rates for services which promotes brokerage , we are seeing a systemic trend in the auto sector whereby the new employment applications are mainly from new university graduates. Those with expertise and experience are choosing to avoid this market due to the low hourly rates. This is compounded by the fact that the other sectors, including the public sector, have become increasingly more competitive.

Proposed Solution:
Experts must be compensated appropriately in order to attract and sustain a roster of experienced health care professionals in the sector. Although this solution appears at first glance to increase costs to the system, we assert that the long-term impact could be the potential to reduce costs. The Professional Services Guideline should be formally reviewed and updated.

10. HOW TO ADDRESS "BAD" PRACTICE OR FRAUDULENT ACTIVITY

Occupational therapists and other professionals have strongly urged insurers to address any concerns regarding inappropriate/incompetent behaviour of a regulated health professional to the health care professional's regulatory college. Regulatory colleges are obliged to address public complaints and to mount an investigation. We note that the College of Occupational Therapists of Ontario reports that between June 2005 and June 2008, Insurers have made four (4) complaints, in writing, directly to the College (from correspondence with Andrea Lowes, Manager, Investigations and Resolutions, College of Occupational Therapists of Ontario, July 8, 2008)

Insurers also have access to a Special Investigations Unit which can be mobilized to address dubious behaviors.

Identified Problem
Reportedly insurers feel that there are not reasonable means through which to address incompetent behaviour or 'bad actor" health professional behaviour.

Adjusters may feel that the task of contacting the regulatory college is arduous and protracted. They might be uncertain as to how to lodge a complaint.

Proposed Solution
OSOT recommends the development of an online resource or toolkit which is available to adjusters and insurance companies on the FSCO website that would facilitate contact and filing of a complaint, provide examples of when to file a complaint, etc. This resource should include;

a. The contact information for each regulatory college including the name of the lead investigator.
b. A form which can be easily completed and submitted to the appropriate College.
c. The contact information of the Health Professions Regulatory Advisory Council (http://www.hprac.org/en/) in the event that the College does not deal with the complaint to the satisfaction of the insurer.

FSCO may wish to contact all Colleges to see if Insurers are making adequate use of this resource.

11. TRANSPORTATION BENEFIT FOR CLAIMANTS

Transportation to and from Medical/Therapy Appointments
Prior to April 15, 2004, all injured persons had access to taxi transportation to/from their medical and therapy appointments. As per the Superintendent's Bulletin No. A 05-04, for accidents occurring on or after April 15, 2004, the non-CAT claimant is no longer entitled to transportation to/from therapy unless their physician or therapy clinic requires travel over 50 kilometres. At the time of this change, the then Superintendent, Mr. Bryan Davies, strongly advised that adjusters should use their discretion and approve transportation assistance on a case-by-case basis, even in the non-CAT situation.

Identified Problems
Unfortunately, it has been our collective experience that adjusters simply deny taxi transportation unless the claimant's travel is beyond 50 km or the claimant has a catastrophic injury. This has been a significant barrier to certain claimants who do not have the financial means to hire a taxi to get to their medical and therapy appointments and their injuries preclude them from driving or using public transit. The situation is further compounded by the reality that it may take up to two years to deem a person catastrophic. During that period, the injured person does not have access to transportation assistance. Ironically, in cases where the claimant cannot access the clinic, the insurer is asked to consider a more expensive alternative—in-home therapy—which increases costs unnecessarily.

This may be a situation whereby the Government attempted to resolve an issue, but the solution was neither beneficial to the consumer nor the insurer, given that the claimant is unable to mitigate his/her losses.

Proposed Solutions

i) We recommend re-instatement of the transportation benefit to all medical and therapy appointments for all injured persons during the first year post-MVA, to cover, at least, the initial stages of recovery. After this period, transportation should only be provided to those persons with catastrophic injuries or, in non-CAT cases, when travel beyond 50 km is required.

Mileage Expense
The insurer is liable to pay a mileage expense to the insured who uses his automobile. In 2004, the claimant was reimbursed at a rate of 27.5 cents per kilometre. On January 21, 2006, the rate increased to 34 cents per kilometer. There has been no further increase.

Identified Problem
We understand that there is no automatic review process to address changes in this particular benefit for claimants. This has become an issue in the past year during which gasoline prices have seen increases of approximately 25%.

Proposed Solution:

i) Engage an annual review of mileage reimbursement rates in concert with the review of the Professional Services Guideline and the fees related to the PAF

ii) Mileage costs should be current and determined using the most up-to-date information from CAA and should take into account wear and tear on the vehicle. Reference: http://www.caa.ca/documents/DrivingCostsBrochure-2008-eng-web.pdf

12. DELAYED PAYMENT OF RECOMMENDED BENEFITS TO CLAIMANTS

Timelines – Specified Benefits (s. 35)

s. 42 Timelines for the insurer to address a Specified Benefits*	
Insurer to notify claimant of payment or an IE after receipt of Disability Certificate	10 business days
Time to arrange the assessment	5-10 business days
Time for the IE examiner to prepare the report	10 business days

Time for the insurer to review the report and send it to the insured	5 business days
TOTAL	**35 business days or 7 calendar weeks**

* Income Replacement Benefit, Housekeeping and Home Maintenance, Caregiver Benefit, Non-Earner Benefit

Identified Problem

Occupational therapists report that claimants do not receive recommended benefits (attendant care, housekeeping, income replacement benefits, non-earner benefits) in a timely manner. This results in undue stress and hardship to the insured when benefit payments are not received in a timely manner to enable them to pay their attendants, landscapers or housecleaners. If income replacement benefits are not paid, some claimants can't pay their bills and experience serious financial hardship.

It would appear that, even though the claimant goes to the effort of securing an occupational therapist who submits an OCF-22 on his/her behalf and after the approved assessment makes recommendations for benefits, the claimant does not have any confirmation from the insurer regarding approval of those benefits. Claimants are sometimes left waiting for monies from the insurer for an indefinite period of time.

In fact, in the Coalition survey, 51.6% of respondents indicated their disagreement or strong disagreement with the following statement:

> *"When I make a recommendation for benefits (attendant care, housekeeping, income replacement benefits and non-earner benefits), the claimant receives those benefits within the regulated timelines."*

Proposed Solutions

i) Upon receipt of the health care practitioner's report and recommendations regarding benefits such as housekeeping, the insurer should be obliged to contact the claimant to:
   i. request invoices for incurred expenses
   ii. inform the claimant as to how payment will proceed, or
   iii. inform the claimant that an Insurer Examination will be requested for a second opinion

   This process/response should occur within ten business days of receiving the health practitioner's report and/or Disability Certificate.

13. HOUSEKEEPING AND HOME MAINTENANCE BENEFIT

Identified Problem

For injured persons who are substantially unable to complete their housekeeping and home maintenance tasks, the $100/week benefit is inadequate to cover meal preparation, house cleaning, general home maintenance tasks and outdoor maintenance. This benefit amount remains the same is provided irrespective of whether the claimant lives in a one bedroom apartment or a one acre farm. This benefit has not been changed since November 1, 1996.

Proposed Solution

The housekeeping/home maintenance benefit should be increased annually with a cost of living adjustment.

14. INSURER PRACTICES

Identified Problems

There are a number of insurer practices that occupational therapists report and perceive to be unfair or deceptive acts or "poor practice". Some examples include;

a) There are some insurance companies that arbitrarily deny ***all*** OCF-22s.

b) Some insurers continue to deny the OCF-22 by requiring the claimant's signature.

c) Insurers receive OCF-18s and fully intend to deny them, however, they wait until the 10th business day before sending their denial to the treatment provider and claimant. This unnecessarily delays treatment for the client.

d) Insurers often order Insurer Examinations that cost far more than the item being examined. E.g. paying $450 for an IE paper review of an Obus Forme back support and pillow costing $165.00.

e) Occupational Therapists are not being paid retroactively once the catastrophic designation has been made despite the fact that, in July 2005 and in subsequent Superintendents' Professional Services Guidelines, the Superintendent attempted to resolve this issue by adding the following clause:

> *"This rate applies to all services rendered on or after July 1 (year) to an insured person whose impairment is determined to be a catastrophic impairment as defined in SABS ss. 2(1.1) (a) to (g) and 2 (1.2)) (a) to (g), whether such services are rendered before or after such determination is made."*

f) Insurers are not paying providers within the 30-day timeframe as outlined in the SABS.

Proposed Solutions

i) The Regulations should provide for automatic retroactive payment to all practitioners who have worked on the file once a claim has been deemed catastrophic.

ii) Continuation of FSCO audits of insurance companies. OSOT is aware of FSCO audits of insurance companies that might identify these practices, however, we are not privy to the outcomes.

iii) The system might benefit from a similar resource or tool kit for health care providers that assists them to take action to resolve problems when they perceive an insurer engages in one or more of these practices.

The Ontario Society of Occupational Therapists is pleased to have the opportunity to share insights and perspectives of occupational therapists working in Ontario's auto insurance system. We look forward to our meeting with you on July 16, 2008 to discuss our comments and suggestions. Please contact me with any questions regarding this submission at any time.

Sincerely,

Christie Brenchley
Executive Director

cc. Arthur Lofsky. Director of Policy, Ministry of Finance

APPENDIX

LISTING OF RECOMMENDATIONS

1. Simplify the Claims Application Forms both in language and structure to facilitate claimants' capacity to complete them independently in a timely manner.

2. Modify the Claims application requirements to enable adjusters to contemplate an OCF-22 to commence assessment and ultimately treatment upon receipt of the OCF-1 alone (assumes OCF-2 and OCF-3 would follow within a defined period of time).

3. Explore the potential to engage a public "help-line", through FSCO or individual insurance companies, to assist individuals who are encountering difficulty completing the Forms. Ideally, this help-line service should be offered in a number of languages.

4. Establish provisions that ensure that the claimant's informed consent is obtained by the health practitioner who signed the OCF-22.

5. Establish provisions that ensure that the claimant is made aware that an OCF-22 has been submitted on their behalf by making it mandatory for the claimant to be provided a copy of the OCF-22.

6. Utilize the data which will be collected through HCAI to identify questionable practice patterns related to requests for assessments. Insurers should be encouraged to investigate such situations.

7. Exploration of the issue of "over" assessment should contemplate Insurer use of assessment and the frequency/cost of Insurer Examinations.

8. Occupational Therapists are best positioned to undertake benefit entitlement assessments given their expertise in functional assessment and retraining and their ability to assess several benefits at one time. Use of OTs should be a system best practice.

9. Establish provisions for insurers to pay for up to a maximum of 50% of the proposed therapy services (only) submitted on a Treatment Plan (e.g., services such as massage, physiotherapy, occupational therapy, chiropractic etc.) pending the final adjusting determination. This should not apply to proposals for equipment, modifications, etc. This would encourage insurers to move swiftly through the determination

process while allowing patients necessary treatment.

10. Shorten the period in which the insurer has to respond to a treatment plan from 10 business days to 5 business days.

11. Modify the Form 1 to indicate that only occupational therapists and nurses may complete the Form 1 and assess for attendant care benefits.

12. Promote Insurers' and health professionals' utilization of existing mechanisms to challenge the competence of Form 1 assessors by making use of regulatory college complaints mechanisms.

13. Introduce provisions in the SABS to permit claimants' access to attendant care benefits retrospectively.

14. Maintain the existing timeline for Insurer feedback/approval of the OCF-22, that is, 3 business days.

15. Occupational therapists are the *best* choice of professional to provide assessment of a claimant's self-care and housekeeping/home maintenance responsibilities within his/her home and provide expert validation of benefit need to the insurer.

16. The additional costs of providing an assessment in a home environment should be offset by the advantage that insight into the home dynamic brings to the assessment and subsequent recommendations. Good assessments give insurers *accurate* information about needs for home modifications, attendant care, housekeeping needs, etc. We believe that, occupational therapists should be the profession of choice for providing "in-home" assessments.

~~17.~~ To control costs of "in-home" assessments whenever possible, the best practice should be promoted amongst OTs to complete a comprehensive assessment when in the client's home that provides opportunity to make recommendations for multiple benefits further to the same one assessment. This cannot be a regulated expectation because client variables will affect the capacity to complete everything in one assessment. Such variables might include; client's tolerance, availability of family members, complexity of injury, client's mental or cognitive status.

18. OSOT is prepared to work further in consultation with insurers, FSCO and occupational therapists if warranted to generate solutions to problems identified with "in-home" assessments.

19. New evidence made available form the recently published research of a10 year retrospective study, (Spine, February 2008, *Bone and Joint Decade 2000 to 2010 Task Force on Neck Pain and Its Associated Disorders*) should be considered as it relates to the treatment of WAD injuries and offers reinforcement of a functional approach to injury management with supported early return to work.

20. To address insurer concerns that claimants eligible for the PAF are treated outside of the PAF, we suggest utilization of the Section 42 paper review provisions to challenge such cases. Data forthcoming from HCAI should be closely monitored for evidence of such inappropriate practice.

21. Propose review of pre and post PAF status of claimants to determine effectiveness of PAF.

22. OSOT strongly supports the continued use of rebuttals as a means for the claimant to have more information in response to an Insurers Examination.

23. Rebuttals should be permitted in cases of OCF-22 denials in relation to catastrophic files only

24. Establish provisions to require Insurer examiners to communicate with the original treatment provider during either a paper review or insurer examination. As well, the appropriate consent for this communication to take place should be included on the respective forms.

25. A response from the Insurer Examiner to a rebuttal should be deemed “best practice” and this response should then be provided to the treatment practitioner.

26. Guidelines should be developed around “best practices” for what Insurer Examinations.

27. The fees for rebuttals should be increased annually to reflect the cost of living adjustment.

28. Experts must be compensated appropriately in order to attract and sustain a roster of experienced health care professionals in the sector. Although this solution appears at first glance to increase costs to the system, we assert that the long-term impact could be the potential to reduce costs. The Professional Services Guideline should be formally opened and reviewed.

29. To support insurer use of existing mechanisms to address concerns about health professional competence or behaviour, OSOT recommends the development of an online resource or toolkit which is available to adjusters and insurance companies on the FSCO website that would facilitate contact with provincial regulatory bodies and filing of a complaint.

30. Establish provisions to re-instate the transportation benefit to all medical and therapy appointments for all injured persons during the first year post-MVA, to cover, at least, the initial stages of recovery. After this period, transportation should only be provided to those persons with catastrophic injuries or, in non-CAT cases, when travel beyond 50 km is required.

31. Engage an annual review of mileage reimbursement rates as is established for the review of the Professional Services Guideline and the fees related to the PAF.

32. Mileage reimbursement rates should be current and determined using the most up-to-date information from CAA and should take into account wear and tear on the vehicle.

33. Upon receipt of the health care practitioner's report and recommendations regarding benefits such as housekeeping, the insurer should be obliged to contact the claimant within 10 business days to; request invoices for incurred expenses, inform the claimant as to how payment will proceed or inform the claimant that an Insurer Examination will be requested for a second opinion.

34. The housekeeping/home maintenance benefit should be increased annually in keeping with a cost of living adjustment.

35. The Regulations should provide for automatic retroactive payment to all practitioners who have worked on the file once a claim has been deemed catastrophic.

36. Develop a resource or tool kit for providers that assists them to understand and engage options for addressing insurer practices they feel are unfair or deceptive.