the Designated Assessment Centres. A key issue was that the removal of neutral evaluations had the potential for introducing practitioner bias. Upon reviewing the recent survey conducted by the Coalition of Health Professionals for auto insurance, we are happy to report to the government that although the changes to the Designated Assessment Centres have occurred, the concept of peer-to-peer evaluation has remained. According to the survey 70% of respondents indicate that their patients are being assessed by peer evaluators.

In some cases, the quality of the section 42 assessments being completed is of question. The lack of established guidelines for performing insurer's examination has resulted in some cases with poor quality. We support the recommendations of the coalition to establish guidelines which would include, years of experience, current practice, education and training.

Secondly, upon reviewing the statistics by our survey, we find that a majority of chiropractors have noted that they are generally receiving approvals for their OCF-18 forms. It is also noted that a reasonable number of OCF-22 requests for assessment, which are sent for independent evaluations, are coming back favourable. This suggests that at times insurer's examination may be pre-mature. We recommend further education to the insurance industry on clinical guidelines so that timely care can be provided without undue costs for assessments.

Rebuttal Examinations

There continues to be confusion both at the professional level and at the insurance level on the purpose and utilization of the Rebuttal Examination. Based upon the SABS, the purpose of the Rebuttal Examination is to provide an alternative opinion and to counter-act any issues that have been highlighted in the independent assessment for the purposes of mediation. In many cases, the insurance companies are not clear on the purpose of this and the members of our profession also are unclear. Despite the original intent of the rebuttal examinations, they have proven to be vital to adjuster's decision making. There are many reports, following poor quality IEs, of rebuttal reports resulting in patients receiving appropriate care which otherwise would have been inappropriately denied.

Insurance companies are also presently asking for secondary opinions regarding the Rebuttal Examinations with respect to Rebuttal Responses, which are provided by the independent medical evaluator. This is adding additional assessment costs and potentially resulting in less money available for medical benefits.

In absence of a neutral evaluation system we support the concept of a rebuttal examination but further education to all stakeholders in this area is required, and the pre-mediation role of rebuttal examinations should be recognized.

OCF-22's

The introduction of the OCF-22 was a result of the industry's requirement that most assessments be pre-approved.

The insurers have highlighted their concerns that an excessive number of OCF-22s are being provided. It is the association's opinion that examples of excessive submissions are isolated cases. The majority of health professionals utilize the OCF-22 process appropriately, and the process is appropriate in allowing their patients to access to those assessment services which are required for the entitlement of benefits.

The timelines and the process that is presently in the SABS is also appropriate, based upon feedback from our membership. It is our opinion that the OCF-22 process should remain as part of the present regulation.

Pre-approved Frameworks

Overall, the membership has highlighted that the Pre-approved Frameworks are appropriate for Whiplash Associated Disorders. The recent changes made by the Financial Services Commission incorporated WAD I and WAD II injuries intro a single PAF. This is reasonable as most WAD injuries treated by chiropractors are WAD 2 injuries. Our survey indicates that 55% of respondents apply the PAF in 75 percent of their cases.

The feedback from the membership states that when injured patients have multiple injuries, the use of the Supplementary Benefits often does not provide a sufficient amount of money to provide treatment for other extremity or back injuries. This gives rise to confusion and disputes over PAF eligibility. Consideration for additional funding for multiple injuries that are within the PAF should be considered.

Recent evidence by the Bone and Joint Decade Study also indicate recurrence of injury and that neck pain is cyclical in nature and may have recurrences. Therefore, caution should be established that although patients may feel better immediately after the accident there is a possibility of increased symptoms at a later date. The industry needs to be educated that the PAF was developed to provide appropriate care for 6 weeks. A certain percentage of patients will require additional care through the OCF-18 process.

Establishing disability benefit time limits on the Pre-approved Framework in our opinion is not appropriate. Pre-approved Frameworks are programs of care focused on treatment interventions and should not be tied in with other benefits. We recommend the removal of the restriction on income replacement benefits and attendant care benefits for claimants who receive the PAF.

Dispute Resolution at FSCO

With the elimination of the Designated Assessment Centres, the dispute resolution process is included for both mediation and arbitration. The length and time continues to be a concern with patients and healthcare providers who continue to wait for outstanding invoices due to delays in the mediation and arbitration process. It is recommended that FSCO continue to monitor the timelines and ensure that accident victims are getting timely responses to their disputes. The specific dispute process in itself, we have no issues with.

Auto Insurance and Extended Health Care

In the present insurance system, auto insurance is the last payer. Specifically if patients have extended healthcare benefits, the process has been that the injured victim has to first submit to his extended healthcare carrier and then after coordination of benefits, the remainder of the outstanding invoices are submitted to the auto insurance carrier. This process both delays access to healthcare and is a very significant administrative challenge for each healthcare professional office.

It is our recommendation that this administrative burden not be the responsibility of the health professional. There are many suggestions for improving collateral benefits including, making the auto carrier the first/only payer, or providing auto insurer's with the ability to collect directly from EHCs.

Conclusion

Overall, Ontario Chiropractic Association's view is that the present insurance system is providing patients with access to appropriate health care services, however, some issues that need to be addressed have been highlighted in the above submission. A full overhaul of the auto insurance regulation system at this point in time is not recommended by the association.

Sincerely,

Robert D. Haig, DC
Executive Director