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COMMENTARY ON THE FINAL REPORT OF THE ONTARIO AUTO INSURANCE ANTI-FRAUD TASK FORCE'S FINAL REPORT

DECEMBER 2012

As indicated in our media release directly following the Report's publication, the Alliance applauds the changes proposed. We believe that by and large the Task Force's recommendations are in the public's interest and believe that the proposed changes should help to reduce criminal activity in the sector, lead to more affordable premiums and improve access to benefits for legitimate claimants. The reflections and suggestions that follow are intended to support and enrich these positive directions.

Overall System

We are pleased to see that the report emphasizes the need for changes focussed on fraud and not across-the-board benefit cuts or process alterations that will negatively affect legitimate claimants. In light of the dramatic reduction in benefits paid out since Sep 2010 as a result of the last round of changes, and with the new emphasis on fraud, we believe there is a need to restore some balance to ensure that those who are genuinely injured have access to the services they've paid premiums for. We believe that greater balance between the interests of insurers and consumers will go a long way to reducing the current and future dispute resolution backlog. We have attached to this document our insights with respect to the current backlog, in the form of a letter sent to the Ministry of Finance in June 2012. We believe that these comments will provide additional context for the observations offered below.

Licensing & Regulation

As FSCO has been identified as the future regulator of health clinics we hope to see an understanding of their responsibility to these constituents. As such, the principle of not overburdening businesses – as articulated in the report - should be front and centre moving forward. For example, the current restriction on providers to invoice only once every 30 days is an example of an unduly burdensome restriction without any causal relationship to fraud prevention. We can support an alternatively articulated limit of once per month, easing the administrative burden on insurers. We believe there should be a forum for regulated individuals and business to bring forward issues such as this for discussions such issues that restrict normal business operations.

Similarly, we believe that recommendation of quarterly attestations by regulated providers is burdensome and unnecessary, and will not lead to better information or accountability. We would like to see this balanced with the recommendation that insurers need to only attest once per year that they are conducting their business in a proper manner.

We support the expectation that facilities shall not invoice for goods and services that have not been provided to a claimant or that have not been approved by the insurer. However, we wish to note that treatment plans are a projection: a 'best educated guess' as to what the provider believes the client's needs will be over the course of treatment, and that reasonable variance within a treatment plan should be permitted if the overall approval amount is not exceeded. For example, one session may last 90 minutes one week, and 45 minutes the next due to a client's fatigue which is often the case. To proceed otherwise is to invite multiple and avoidable disputes from arising.

We fully support the expansion and use of Professional Credential Tracking.

With respect to the Transparency and Accountability requirements outlined in Appendix 6, we suggest clarification and more nuanced requirements for the Designated Regulated Professional (DRP) to be "on site" when companies have more than one physical location. For example, if an organization has three sites, the DRP will likely not be able to be on-site 3 days per week at each of 3 locations, but will be on-site every day or most days at one or another of the locations.

We support the intention to license both treating and assessing/IME (Independent Medical Examiners) providers. In addition to asking insurers to report on the selection process for IME providers, increased transparency in the selection process would be of benefit. A more formalized procurement process in which multiple providers have an equitable opportunity to bid on the work would be a positive step. This would allow smaller providers to work directly for insurers and be less dependent on the largesse of the dominant IE provider companies.

Additionally, transparency will be further improved if denial patterns by IE companies are analyzed and reported on. We support the requirement to have IME's acknowledge that their opinions are not subject to undue influence, but this will need to be properly defined to avoid the possibility of IME companies asking providers to change their reports (as has become the case regularly since September 2010). We would like to see the role of HCAI expanded to include the collection, analysis and reporting of such data and believe that publicly reporting this data will enhance transparency and prevent that degree of opportunistic fraud that arises out of provider/client frustration with arbitrary insurer decisions.

Complaints

We understand the usefulness of a risk-based audit approach and that FSCO will be conducting such audits based on a number of factors, including complaints. However, we are mindful of the possibility that some insurer-initiated complaints could arise from relatively trivial matters. There is also the possibility that adjusters could misuse the complaints process to 'punish' healthcare providers who stand their ground throughout a dispute. In order to prevent and mitigate the possibility of such types of retribution and avoid numerous, costly, disruptive and unnecessary audits there should be clear

guidelines that reflect these considerations and that outline when a complaint can be made and under what specific circumstances.

We suggest that there should not be 'automatic audits' triggered by the 'wrong' or trivial sort of event, such as when an invoice has been accidently submitted at 29 days instead of 30. Further, we suggest that a fee of $500 or $1000 be levied to insurers in order for FSCO to initiate an investigation, as is the case with mediation. This will help ensure that audits take place in response to legitimate and substantive issues. Further, we suggest that the basis for complaint be limited to infractions with respect to the Accountability: Business Practice Standards**,** listed on p.155 of the report.

We agree with publicly releasing how complaints are handled.

We agree with publicly releasing how insurers choose IE companies.

We fully support the whistle blower hotline, and protection for whistle blowers.

We support for changes to UDAP (e.g., no signing of blank forms).

Imbalance of Sanctions

Sanctions are of paramount importance if anti-fraud measures are to be effective. However, we believe that sanctions should be applied more equitably than the report suggests if the system is to be fully accountable, and for insurer behaviours to change as well as those of healthcare providers'. Most importantly, it will serve to demonstrate to the public that their interests as consumers are being served. There must be 'teeth' behind the requirements for appropriate insurer behaviour and there must be consequences for insurers and IE companies who fail to fulfil their obligations, just as there are for providers.

Currently, very many disputes arise because insurers do not provide their reasons for failing to approve a treatment plan, even though there is requirement that they do so is in the SABS. We appreciate that the Task Force noted this problem, and responded with a recommendation: *that the government revise the current SABS section 38(8) to clarify that a claim denial describing a claimant's request for goods, services or assessments as* ***"****not reasonable or necessary" is not sufficient to be compliant with section 38(8), which requires a claim denial notice to list the "medical and all other reasons****."***

We feel strongly that there must be consequences attached to non-compliance or this important obligation will continue to be ignored. After all, insurers are already ignoring this requirement, which is very clearly articulated by the Regulation. The report does not outline what, if any, penalty will be imposed on insurers that do not provide proper explanation for denial of benefits.

Similarly, we believe that failing to respect the Conflict of Interest guidelines must be married to specific sanctions.

By introducing tough penalties for healthcare providers (to the point of business cessation) and none for the insurers, we believe that that the Task Force is sending the wrong message: that protection of insurers is paramount to protection of consumers and victims. If this is not the intent then the playing field should be levelled by the introduction of punitive provisions similar to those imposed on the Healthcare providers. For example if insurers do not comply with business practices imposed on them, an investigation should be launched by FSCO and penalties imposed. While an equitable treatment would dictate cessation of business, we call for very punitive fines, which will be meaningful to the overall financial performance of the guilty insurer. If insurers are already conducting their business ethically and according to the Regulations there should be no objection to this recommendation on their part, similarly to the manner in which we have supported punitive measures to healthcare providers who currently abuse the system. We believe that this will go a long way to reduce the number of disputes and improve confidence in the system by consumers.

We support the role of the Colleges to develop standards for IE assessors.

We suggest caution and clarification of the requirement for claimants to pay for a missed IE appointment; there should be no requirement to pay if the insurer/IE company provides the wrong address, date or time (on written document) to the claimant, for example.

Provider Input

We support, and will gladly offer assistance with the consumer education initiative, specifically with respect to providing insight into what is and isn't 'normal' clinic practice, and what best business practice looks like, both for treating providers and IE assessors.

We believe that we have an important contribution to make as a representative of providers whose focus is significantly on this sector. The Alliance represents members who work in this sector on a daily basis versus Associations which at times have a peripheral view. We believe that the Alliance should be a part of the advisory committee to FSCO's regulation group. We further believe that our significant contribution to the Anti-Fraud Task force, which adopted many of our recommendations, is testament to our core beliefs and values in ethical and fair conduct.

The proposed website should provide consumers with a list of 'red flags' by which they might identify inappropriate provider or IE behaviour.

We support the recommendation that real or potential conflicts of interest be disclosed by the clinics to their claimants. But we feel this must go further: in a scenario where an independent adjusting company also owns an IME company, it should be the insurer who discloses such information in the interest of public protection. Our earlier recommendation that denial patterns be published would be an excellent adjunct to this requirement so that if a company owned by an insurer has a much higher denial rate than other companies that could be noted and investigated.

We are unclear if the recommended requirement is for IE clinics to disclose fees paid to assessors, to insurers, or to the public? We believe it should be publicly disclosed, just as the FSCO fee schedule is publicly disclosed.

We support the requirement to have all providers, including IE companies and vendors register and submit invoices through HCAI.

Conclusion

We wish to thank the Task Force for the time and attention they have given to this issue, and for the positive road map forward that their report provides.

We hope that with the introduction of these fraud-targeted measures that FSCO will undertake a review of the 2010 across the board cuts to legitimate victims in order to return much needed health care provision to this sector.

The Alliance of Community Medical and Rehabilitation Providers is a non-profit association representing more than 90 service provider organizations employing more than 3500 professionals. It is these physiotherapists, occupational therapists, speech language pathologists, chiropractors, psychologists, rehabilitation therapists, social workers, personal support workers, nurses and case managers who are the primary providers of healthcare and rehabilitative services to Ontarians who are injured in automobile accidents.

We would be very pleased to offer additional thoughts, or to clarify or elaborate on any of the above.

Respectfully submitted on behalf of the Alliance of Community Medical and Rehabilitation Providers

December 6, 2012.

Alliance of Community Medical & Rehabilitation Providers

June 12, 2012

Andrew Kovarciuk
Ministry of Finance
Via Email

Dear Andrew,

Re: ADR Backlog and Polarization of Medical Opinions

Following our meeting with you last November, we arranged a meeting of representatives from the Alliance of Community Medical and Rehabilitation Providers (the Alliance), the Coalition Representing Health Professionals in Automobile Insurance Reform (the Coalition) and the Association of Independent Assessment Centres (AIAC). Together, we brainstormed explanations for the increasing backlog as well as possible solutions. We have then continued consultations with a variety of other stakeholders in this industry. This letter serves to summarize the Alliance's thoughts on these issues and we look forward to meeting with you to discuss further.

There are likely a myriad of reasons for the 30,000+ backlog in the ADR system, and hopefully there will soon be data on the nature of the cases comprising the backlog to allow more refined analysis. On a purely logistical level, with providers and legal reps anticipating the September 2010 changes, there would have naturally been a dramatic increase in service applications and CAT rebuttals in the months before September 2010. However, there are a number of systemic issues which we believe are significant contributors.

It is important to point out that the systemic September 2010 changes will have the unintended consequence of deferring costs. We find ourselves in a situation now where insurers are denying almost triple the number of assessment and treatment plans with less than half of these denials being sent for a second medical opinion (insurer examination). Although we understand that few of these disputes have actually begun to be processed through the system to date, it is predicted that this fact alone will continue to place a high demand on mediation/arbitration systems. If such a prediction is accurate, the current state presents a distorted view of overall system cost and outcome effectiveness because of the associated deferred costs and delayed rehabilitation. Such deferred costs include those of future ADR and anticipated increased tort awards due to poorer claimant vocational and functional outcomes associated with blockage to timely access to rehabilitation.

We will first review some general developments over the past couple of years which will contribute to the ADR backlog, and then we'll review issues that relate specifically to the polarization of opinions between treating providers and IE assessors.

- Insurers, usually without medical training, frequently choose to deny assessment and treatment requests without seeking out an IE
- With the absence of IE time lines, insurers are suppressing medical evidence by keeping IE reports hidden for lengthy periods of time and choosing to deny funding for progress reports prepared by treating providers to limit the providers' ability to document rehabilitation procedures and outcomes
- Insurers are not supplying the "medical and other reasons" for denying assessment and treatment requests

    - *This results in a lack of confidence in insurer adjudications, pushing lawyers to resort to mediation/arbitration*
    - *This also results in increased time for insurer examinations and mediations when each side must perform more comprehensive investigations into broader issues, rather than being able to focus on what the insurer's particular concern is*

- There does not appear to be a "triage" process for mediation/arbitration requests and therefore all cases are treated in the same manner

    - *The nature of the dispute can sometimes be quite minor and/or obvious and could be resolved with an alternative process rather than requiring the full resources of mediation/arbitration*

With respect to factors which appear to be contributing more specifically to the *polarization* of the system, we offer the following observations:

- Insurers have more power to dictate which assessor they want to use (versus a geographically or alternate choice based assignment as in the DAC days) with the result that IE companies are more likely to try to influence assessor opinion in order to please insurers
- As seen through our survey, insurers are increasingly choosing non-peer evaluators when they do insurer examinations (e.g., requesting a family physician to review a request for speech-language pathology services)
- The Unfair and Deceptive Acts and Practices regulation was significantly dismantled to remove an insurer's obligation to select appropriately qualified personnel
- Since the dissolution of the Designated Assessment Centre (DAC) system, there have been no standards applied for qualifications of IE assessors so we have seen an alarming increase in the number of IE assessors who possess substantively less skill and experience than the treating providers whose work they are being asked to review
- The $2,000 fee cap is shifting emphasis to seeking low cost assessors instead of highly skilled assessors

    - *This results in a mismatch in expertise levels, which contributes to a polarization of opinions (e.g., while a family doctor technically has a scope of practice that subsumes most disciplines, research has shown that they make correct decisions regarding cognitive-communication disorders in less than 4% of cases)*
    - *Most disciplines have a range in their scopes of practice, so it is not a violation of College standards for an individual to provide commentary on an area they may*

not have the best level of expertise in, which then results in a mismatch in expertise and therefore a polarization of opinions

- *If the IE assessor has less skill and experience than the treating provider, there is a much higher likelihood of a dispute*
- *Many individuals now being hired to do IE assessments have limited knowledge of applying the SABS regulations, so even if their clinical knowledge is adequate, their ability to map that onto SABS funding requirements may not be*
- *As documented in a number of arbitration decisions the assessment cap is resulting in an increased number of cases where IE companies are writing reports based on verbal or point form observations made by the actual assessor.*
- *As illustrated at a previous meeting with you, some IE companies are openly instructing their providers to limit review of the medical file in order to provide services at a lower cost.*

- Checks and balances (such as requiring an IE and allowing treating providers to prepare rebuttals to an IE) have been removed

    - *With no option to rebut an IE report, the treating provider is prevented from highlighting areas of weakness in the IE report which might alter the insurer's decision, which then results in referral for mediation*

- With advances in road construction, vehicle safety and medical procedures, more injuries are in the milder range

    - *It is in the milder range, the "grey areas" where there is naturally more disagreement because impairments are not as obvious*

- With the 95% reduction in benefits for minor injuries and the 70% reduction in benefits for serious but non-catastrophic injuries, there is more incentive to look for additional funding for injuries sustained

    - *The evidence is mounting rapidly that the new limits do not provide sufficient funds for many injuries, so it is in the disabled person's best interest to try to get reclassified into the next higher funding category*

The DAC system was certainly not perfect, however there were a number of features that were effective. To provide a summary of the pros and cons of the DAC system:

<u>Cons</u>

- Some DACs had previously largely been IE facilities with more of an insurer leaning, thus not perceived as neutral
- Lack of fee constraints for many (not all services) & lack of competition likely inflated some assessment costs
- Earlier DAC protocols allowed a given DAC to only address one benefit; this was later appropriately rectified so that multiple entitlements could be addressed in given referral

<u>Pros</u>

- Inherently more neutral given decreased linkage between referring insurer and IE centre; no contractual relationships which tends to lead to centre/insurer bias
- Assessors rarely felt pressured to give an insurer a leaning opinion (other than with some more insurer oriented facilities, but even there to a lesser extent it seemed)
- Clinical protocols were more best-practice based rather than low cost driven (e.g., IE companies are encouraging assessors to not review all documentation in order to save time)
- Clinical protocols were more uniform as at least some had DAC Manuals
- Higher level of clinical qualifications established maintained in transparent manner (DAC Assessor Summary)
- Better communication/education of assessors through annual ADAC conferences and re FSCO communiques re best practices and relevant court/arbitration outcomes to update/inform assessor opinions
- Through DAC statistical reporting to FSCO, better opportunity for FSCO to monitor outcomes and potential bias (although this potential seems not to have been fully realized)
- No known conflict of interest concerns in relation to insurer ownership of DACs
- Stringent conflict of interest guidelines with respect to DAC assessor pre/post involvement on given file

Our solutions to these problems are as follows:

- Insurers must be required to supply their "medical and other reasons" for denying an assessment or treatment plan to the treating healthcare provider in all cases with lack thereof resulting in a UDAP.

- Guidelines need to be developed for insurers to know when an IE is necessary (e.g., an IE should be required anytime insurer challenges a request to move to a higher benefit category and at least when denying the first request for assessment or treatment on a file). We have representatives who will happily assist with the development of such guidelines.

- Standards for IE assessor qualifications and procedures need to be developed. This requirement was recommended as part of the last round of reforms, but has not been acted upon to date. As a starting point, prior DAC minimum assessor qualifications standards and competency form should be reviewed. The Ontario Association of Speech-Language Pathologists and Audiologists voluntarily created such guidelines and submitted them to FSCO for review in the fall of 2010 (copy enclosed). For example, IE assessors should be required to have a minimum number of years experience in the area they are reviewing, and they should have a balanced practice (e.g., they conduct IEs and also teach at a recognized College or University; or they have a treating practice in addition to conducting IEs; etc.).

- Insurers should be held responsible for using IE assessors who they know to be unqualified. There are many historical examples of unqualified or openly biased IE/IME assessors who the insurance industry has used on numerous files resulting in real hardship and permanent damage to victims.

- IE Assessors' qualification summaries should be easily available for anyone in the system to review (e.g., in the OSLA program, anyone can contact OSLA and obtain a copy of the qualification information submitted by the IE Assessor)

- Acknowledgement duty. In parallel with recently enacted requirements for medical-legal assessments, IE assessors should sign a similar Acknowledgement to Form 53 (copy enclosed) requiring the assessor to pledge to adherence to the principles of objectivity, neutrality, and evidence-based opinion. Such an acknowledgement would be affixed to each and every IE assessment report.

- Return to like for like (peer) assessments. In performing IE assessments pertaining to OCF 18 reviews, the IE regulated health assessor should be of the same discipline as the proposing clinician/OCF-18 plan supervisor (or clinically most aligned assessor if there is a better fit for the proposed plan). Our membership reports that like-to-like assessments are not conducted in 35% of all cases. This has the tendency of sparking disputes as victims representatives claim that an IE was performed outside of the scope of the assessor.

- Required certification/training/continuing education for IE assessors. This concept would for example serve to assure that IE assessors remain knowledgeable and current about rehabilitation focussed clinical best practices, pertinent MVA regulations and case law relevant to entitlement determinations

- Allow rebuttals in response to IE reports

- Re-establish timeframes for referral and completion of IEs

- Restore non-cat non-MIG funding to $100,000 plus assessments

- Business ethics standards need to be developed for both clinician and IE organizations. The Alliance shared a draft of such standards with the Anti Fraud Task Force in December 2011 (copy enclosed).

- HCAI and other systems could provide feedback to treating clinics and IE assessors regarding performance relative to average. However, such data would need to consider claimant demographic considerations as well as consideration of the origin of arising disputes (e.g., treatment plans arising from rogue clinics wherein those plans are rightly denied and are highly represented within an IE clinic/provider's referrals).

- Contractual relationships between insurers and IE companies should emphasize quality and timeliness of assessments and adherence to operating principles rather than cost.

- There should be transparency in the RFPs posted by insurers describing the desired contractual requirements for IE companies to adhere to, and the selection process IE companies will go through for the RFP

- The selection process for insurers to obtain an IE on any given file needs to be reviewed for methods to improve neutrality

- IE companies with a majority ownership by insurers or adjusting companies should not be permitted to operate within the system due to the perceived and/or actual conflict of interest

- The $2,000 assessment fee cap needs to be removed to return to an emphasis on quality instead of cost. A number of individual associations have submitted proposals for an improved assessment cap system on the treating provider side and similar proposals could be reviewed on the IE assessment side.

It is recognized that bias may be present both in IE assessors as well as in treating providers. However, there are checks and balances in the system to manage bias in treating providers (e.g., insurers can deny assessment and treatment requests and can request an IE opinion). The reason we emphasize the need for reducing IE assessor bias is because all the checks and balances to monitor their work were removed in September 2010. Treating providers have "carrots and sticks" to encourage good work, but IE assessors do not. On the IE side, the incentive is in fact to the contrary – i.e. the more requests an IE assessor denies the "better" he/she is in the eyes of the insurer.

We also understand the government's confusion when most ADR settlements are for cash rather than treatment, which calls into question the value of treatment. However, two things must be kept in mind:

- Some providers and lawyers agree to provide treatment while awaiting the outcome of the ADR process given that the process is so lengthy, so cash is needed to reimburse the provider(s) for these services.
- When a client goes without treatment for a year or more, the benefits of treatment are reduced and the client begins to feel in an entrenched hopeless state.
- When brain injury is the diagnosis, poor decision making is a common characteristic so clients who could benefit from ongoing therapy sometimes choose to spend money on more concrete items. To see the true outcome for these individuals, the government needs to look a couple years down the road post-settlement. The prevalence of institutionalization for psychiatric disturbances and criminal offences is high. The Ontario Brain Injury Association has some excellent data regarding this.

Finally, additional clarity is needed when comparing Ontario's accident benefits system and those found in other provinces. It is our belief that when apples are compared to apples, Ontario's system is the second poorest in the country. This belief is based on a weighted average calculation of benefits available to different injury severities and different levels of public funding available in other provinces (e.g., there is next to no rehabilitation funding in Ontario anymore). The Alliance is planning a study in this regard.

The above is meant not only as a solution to address the backlog in the ADR process but also to bring transparency and fairness to the system. We believe that the public is losing confidence in the system. This is clearly contrary to the intent of the insurance product which is supposed to bring peace of mind to its consumer. We believe that the recommendations provided herein will address this issue.

We trust that this document is the first step in outlining out thoughts on the subject, but hope that the government will continue to work with us on drilling down on the topics covered herein to resolve the issues which are plaguing the ADR process.

Sincerely,

The Alliance of Community Medical and Rehabilitation Providers