Alliance of Community Medical & Rehabilitation Providers

51 Sophia Street
Peterborough ON
K9H 1C9

www.ontariorehaballiance.com
Toll Free: 866-475-2844
Toronto: 647-317-7244

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COMMENT ON SABS REGULATORY AMENDMENTS MADE IN FOLLOW UP

TO ANTI-FRAUD TASK FORCE RECOMMENDATIONS

As indicated in both our Media Release and subsequent formal submission to the Ministry of Finance, the Alliance of Community Medical and Rehabilitation Providers (the "Alliance") applauds the work completed by the Anti-Fraud Task Force.

On January 22, 2013, the Ministry of Finance released new regulations that were reported as following through on some of the recommendations made by the Anti-Fraud Task Force. On January 11th we provided input to a consultation on the proposed changes and followed our presentation with written comments which are again referenced here. While the Alliance did not object to or see any problems with most of these regulations, we did take issue with two of them. In these two instances it is our view that the regulatory language is contrary to the recommendations made by the Anti-Fraud Task Force and will result in added hardship to the victims. We address areas of disagreement below:

Amendment to S.38.8

The language of this section has been amended as follows:

> FROM:
> "Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical and ***any*** other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary"
>
> TO:
> "Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical and ***all of the*** other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary"

The change to this section of the SABS was to be based on the following statement made by the Anti-Fraud Task Force on page 32 of their final report:

> "We have heard reports that, in some cases, insurers are denying payments of medical and/or rehabilitation benefits without providing adequate reasons for the denial, for example, by providing a limited, non-specific explanation, such as "not medically reasonable or necessary."
>
> "We therefore recommend 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".

There are two observations that are worth making with respect to this regulatory amendment: 1) The change to the regulation, substituting the word "any" with the words "all of the", makes no difference to the interpretation or actions required by this paragraph at all; and, 2) It does not deal with the fact that as stated by the task force "…insurers are denying payments of medical and/or rehabilitation benefits without providing adequate reasons for the denial…"

We are concerned that of the 38 recommendations made by the task force this (#4) is *the only one* that was made with the protection of victims in mind. Notwithstanding, the new language fails to accomplish exactly that.

In order to properly protect victims, the prior language could have been left unchanged, but what is lacking is the consequence to the insurer if this provision of the SABS is not followed. Major consideration must be given to the fact that the Task Force has recognized what victims and healthcare providers have known since the 2010 regulatory changes were made: by removing the mandatory IE process and providing insurers with ample discretion, victims' abuse has increased. There are serious consequences to rehabilitation, well documented in clinical literature, that stem from delay in timely treatment. The government seems to have missed an opportunity to follow the Task Force's recommendation and protect the victims while at the same time putting an end to the creation of disputes such as the many that have previously arisen due to the lack of articulated implications for non-compliance with this section.

Recommendation

We recommended and maintain that the Task Force's intention should be accomplished through one of the following two measures: 1) Designate breach of 38(8) as an Unfair and Deceptive Act or Practice (UDAP); or, 2) clarify S.38(11).2 to state that failure to provide "medical and other reasons for the denial under S.38(8)" is considered breach of that clause with the subject treatment and assessment plan deemed approved. Technically, according to the regulation this is already the case, however, a clarification would achieve the intended goal of the Task Force and send a message to adjusters that a denial based on the reason of "not reasonable and necessary" does not constitute a denial at all.

Addition of S. 46.3

The following new section has been added to the SABS:

> 46.3 (1) An insurer may request any of the following information from an insured person who submits an invoice to the insurer for payment for goods or services under this Regulation, or from an insured person on whose behalf such an invoice is submitted:

1. Confirmation in writing that the goods or services were provided to the insured person.
2. A statutory declaration as to the circumstances that gave rise to the invoice, including particulars as to when, where and by whom the goods or services were provided.

(2) The insured person shall give the insurer the information requested under subsection (1) within 10 business days after receiving the request.

(3) For the purpose of section 51, the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which an insured person fails to comply with subsection (2).

The addition of this section into the SABS was reportedly based on the following statement made by the Anti-Fraud Task Force on page 63 of their final report, and is in fact based on our recommendation to combat fraud (emphasis ours):

"Three of the changes to the Statutory Accident Benefits Schedule (SABS) identified in our Status Update as potential recommendations were related to the detection of fraud. These changes will provide collision victims with more information about their claim that can be reviewed for suspicious activity.

1. *Require claimants to confirm attendance at treatment facilities*
   The SABS should be amended to require *health care providers and assessment facilities to ask claimants to sign a form each time they receive a treatment*. Copies of these forms would be kept on file and *made available for inspection at the time of audit*.

2. *Require claimants to confirm receipt of goods and services billed to insurers*
   The SABS should be amended to require *providers of goods and services to ask claimants to sign a form when they receive goods*, such as back supports or orthotic shoe inserts. Copies of the forms would be kept on file and *made available for inspection at the time of audit*. "

We note that the new regulation is a far cry from that recommended by the Task Force (and one we originally endorsed).

First, while the Task Force clearly put the obligation for tracking attendance on the healthcare providers and product vendors, the regulatory language has turned it into the claimant's obligation. The root of the problem is that the penalty for inappropriate tracking of services by the claimants will translate into non-payment of an invoice to the service (or product) provider despite delivery by the latter. It is difficult enough for most healthy people to recall their past daily schedules in detail let alone asking those suffering from mental illness or brain injuries which affect memory. Seriously injured accident victims face significant hurdles getting better and putting their lives back together. These added administrative responsibilities are unreasonably burdensome.

Secondly, the Task Force clearly referred to an attendance log for treatment sessions. The new regulation lacks such language and refers generically to "good or services". It needs to be understood that many services that insurers are billed for cannot be verified by the claimant. For example: claimants will not be able to verify the time consumed by a healthcare provider while writing a report or filling out a form, arrangement of equipment by a therapist, coordinating hospital discharge,

analyzing/scoring an assessment tool and the list goes on. As a matter of fact, much of the role of a Case Manager who deals with Catastrophically Injured victims cannot be subject to verification by the claimant as it is mostly done behind the scenes. Providers are also mandated to use codes from the Canadian Classification of Health Interventions (CCI) on invoices. This is not a simple coding system for providers and insurers to understand, and will certainly not be easily understood by injured clients and their families. Not limiting the requirement to tracking treatment sessions only, as astutely proposed by the Task Force, will result in a meaningless measure which will in turn result in endless disputes.

Thirdly, the Task Force clearly noted that attendance or product delivery logs which are to be tracked by providers shall be produced for inspection at the time of audit only. In stark contrast, the regulatory language lacks such restriction which means that victims may be asked for proof upon every claim for payment.

Granting such carte blanche to insurers to demand proof prior to issuance of payment will undoubtedly (based on past experience – refer to the first section of this paper dealing with insurer abuse under S.38(8)) lead to even more unreasonably delayed or denied payment by adjusters. This will then lead to more disputes, adding to the current backlog in the ADR process.

During our work with the Anti-Fraud Task Force we consistently warned against the "drag-net fishing" effect where honest, innocent victims or healthcare providers, who make up the vast majority of both groups, are imposed with additional burdensome measures in the name of fighting the fraudulent activities of a very small group. In response, the Task Force acknowledged that the vast majority of claimants and healthcare providers are honest and are not involved in fraud. In fact on p.13 of the Task Force's final report a major guiding principal to that end is articulated as follows:

> ***"Our recommendations should not make things worse for legitimate claimants."***
>
> "Our recommendations are targeted directly at fraudulent behaviour. *They do not disadvantage legitimate claimants*. Indeed, we believe that effective implementation will take pressure off the system, allowing legitimate claimants to experience less uncertainty and delay before obtaining the benefits to which they are legally entitled."

Regretfully, this new regulation will achieve the exact opposite of the abovementioned principal put forth by the Task Force by requiring all claimants to keep a log of every minute detail of their healthcare services. The unintended message might be that every claimant is a fraud suspect.

Recommendation

Our recommendation remains that the regulation should reflect the exact wording recommended by the Task Force. Such wording requires healthcare providers and equipment vendors to keep a signed log sheet of treatment sessions and equipment/supplies delivery. Such log sheet maybe called upon at the time of audit. The accountability mechanism will be for insurers or auditors to provide such log sheets to claimants for confirmation of their signature. It will achieve exactly what the Task Force intended without "disadvantaging legitimate claimants" and honest healthcare providers.

Summary

While the Alliance accepted most of the regulatory changes, the two discussed within this paper were identified as particularly worrisome. We believe that it is a great disservice to the intentions of the Task

Force that the regulations have in fact been adopted as proposed. The new regulations fail to follow the spirit and the letter of the Task Force's Final Report in two areas: 1) They fail to implement the only consumer protection measure that the Task Force recommended; and, 2) they fail to keep the promise of "not making things worse for legitimate claimants". We are concerned that the implementation of this new regulatory language might be interpreted as not only failure to protect the victims but in fact punishing them in the name of fighting fraud. We feel strongly that in order to capture the intent of the Task Force's recommendations the regulatory language must be amended in line with our recommendations provided in this paper.

The Alliance is thankful for the opportunity to provide feedback and is looking forward to continue playing an integral role going forward.

We would be pleased to discuss and answer questions related to this paper anytime.

Sincerely,

Justine Hamilton
Vice President