From: **FAIR (fair association of victims for accident insurance reform)** <fairautoinsurance@gmail.com>
Date: Thu, Mar 20, 2014 at 9:47 AM
Subject: FAIR treatment of MVA victims and Bill 171
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March 20, 2014

OPEN LETTER

Sent by email to Premier Wynne, Charles Sousa and Deb Matthews
CC to Ontario's MPPs and the Media

On March 17, 2014 Ontario's legislature had the second reading of Bill 171 - Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014.

FAIR believes that Bill 171 is being rushed through by our government to increase insurer profits.

There are clearly issues that both the NDP and the Progressive Conservatives feel are worthy of further consultations before passing 171 into law. It is only the Liberal party who felt that "this bill, if passed, is a practical step in helping us curb the price of auto insurance." As if it doesn't matter what we get for the money or that right now, only half of all accident victims are getting the benefits they've paid for isn't a big issue.

Accident victims see Bill 171, not as a fraud fighting measure but as a template for reducing benefits paid to injured drivers by way of legislation geared toward enhancing insurer profits and marginalizing the rights of Ontario's disabled and injured citizens.

What kind of government creates laws that discriminate against injured and disabled citizens by denying them the same access to justice that every other citizen enjoys in a democratic society? Why remove the disincentives for insurers who delay and deny legitimate claims by decreasing prejudgment interest rates and throwing away 'special awards' for claimants who have been unfairly abused at the hands of their insurer? It's like declaring war on vulnerable MVA victims and it has nothing to do with fighting fraud.

Not a word from the Liberals about the core reason for the rate of insurer denials that created the backlog in our courts systems in the first place. Bill 171 will leave us with a dishonest system based on too often flawed and biased medico-legal opinion reports that are used to deflate and deny legitimate claims – but it will be faster. Not better, not honest, not helpful and certainly not fair or just.

What kind of government commission studies and panels that continue to acknowledge the issue of the quality of the medical examinations that accident victims are subjected to but still doesn't act to protect the best interests of the public? One that is determined to keep the self-regulation for medical practitioners in place despite that it is causing so much harm to its most vulnerable citizens?

The Anti-Fraud Task Force acknowledged the problem with IME/IE reports and expert evidence and chose to do nothing. And Justice Cunningham spent some time on the subject in the DRS Review Report and again, there are no meaningful recommendations to fix this harmful process that is at the core of many of the cases that are in dispute. The recommended non-payment for a court appearance is hardly more than a slap on the wrist. Both of these panels have recommended that the system and the accident victims continue to rely on Ontario's regulatory colleges for oversight in respect to the quality of medical examinations and reports. A system they acknowledge isn't working and that consumers and patients have issues with. Doing nothing about this harmful problem is an insult to every accident victim that has had to attend these IMEs and to every respectable assessor who does try and do a decent job.

If there were to be an end to the unqualified or bogus IME/IE, it would be an end to the high volume of cases in dispute and an end to much of the suffering and psychological harm done to victims by these rogue assessors. Does this government have something against the fair treatment of accident victims with the use of quality evidence in court?

It can only be seen as a willful decision to put on the blinders to this harmful practice of abuse by some of Ontario's insurers and their assessors. It's dangerous out there for the cognitively impaired or highly vulnerable accident victim when colleges such as CPSO have a long and dark history of hiding facts and misleading the public to protect their members. Both the Anti- Fraud and the DRS panel had information in front of them, words spoken by other judges and arbitrators on the harm caused by these partisan assessors and about the lack of transparency at Ontario's colleges.

CPSO sends third party assessors for confidential remedial cautions when they abuse accident victims and when these same vulnerable people appeal these secretive and dismissive decisions, HPARB anonomizes the practitioners name so that no matter what – accident victims will never know about prior abuse, bias or poor report writing skills or that unauthorized rubber stamped reports are being used.

We see no interest in real regulation when it comes to Ontario's insurer assessment mills and their shoddy and biased medical reports with accusations of symptom exaggeration. In fact we see the opposite. We see recommendations by the Anti-Fraud Task Force Panel to fine injured claimants $500 if they fail to submit to often sketchy insurer assessments. Assessments that everyone in the industry and at FSCO knows are questionable, assessments without real oversight that everyone, except the general public and vulnerable accident victims, knows about.

We see the DRS Panel making recommendations to strip injured claimants of the right to take their cases to court. Instead of punishing rogue insurer assessors with fines or fraud charges – we see 'special awards' being eliminated and the power of FSCO Arbitrators to refer insurer misconduct to the Market Conduct Branch removed. No more remedies for wrongful claims handling practices and all of these measures hurt MVA victims and reward insurers for abusive conduct and delays.

Please stop trading accident victims' rights to fair hearings, and the benefits they need for recovery, for insurer dollars.

Please fix the quality of the medico legal reports that are used to decide whether an accident victim is entitled to rehabilitation and benefits and in the bargain you'll get a fair court system that isn't clogged with legitimate accident victims who have wrongfully been denied benefits. Please recognize that when the Colleges don't do their job and aren't transparent to the public so their members not held accountable - and then the Health Professions Appeal and Review Board helps them to mislead the public - it causes serious harm. Please fix that by making sure the Colleges really are acting in the best interests of the public they are charged with protecting. Please don't make it easier for some unscrupulous insurers to delay claims so they can make more money by paying a lesser interest – it creates an incentive to deny claims.

Please stop capitulating to Ontario's insurers and discriminating against those whose insurers have failed to stand behind their contracts by taking away their right to have their case heard. Stop letting assessors harm accident victims and start making regulation and enforcement work.

Please stop taking action that has made Ontario's accident victims third class citizens and in the bargain allowed Ontario's insurers to walk away from their responsibilities by downloading these costs to the taxpayer.

Sincerely yours,

Rhona DesRoches

FAIR, Board Chair

http://www.fairassociation.ca/wp-content/uploads/2014/01/FAIR-submission-to-2014-Pre-Budget-Consultations-Jan-23-2014.pdf

http://www.fairassociation.ca/wp-content/uploads/2014/01/FAIR-letter-to-the-DRS-Panel-January-15-2014.pdf

From http://www.fairassociation.ca/the-independent-medical-examination-imeie/

Singh and State Farm [+] Arbitration, 2014-02-21, Reg 403/96.
Expenses FSCO 4128.
I also found that State Farm did unreasonably delay the IRBs to which Mrs. Singh was ultimately entitled. It had no reasonable answer for not reconsidering her benefits after May 2, 2008 and relied on defective or incomplete reports to terminate those benefits, hence the special award.

4. As part of her practice as a registered physiotherapist, the Respondent is regularly retained by medical assessment companies and insurers as an independent third party assessor to perform examinations to assist in determining the reasonableness and necessity of continued coverage for physiotherapy treatment.

5. In performing her assessments, the Respondent reviews the medical records provided to her by the insurer and may conduct an examination, which includes taking a history, and performing a physical examination and testing of the subject. In other cases, the Respondent bases her assessment solely on a paper review of the subject's medical file. The nature of the assessment and the content of the medical record reviewed by the Respondent are determined by the insurer.

6. The Applicant was referred to the Respondent for six independent assessments. The Respondent provided in-person, physical examinations of the Applicant on four occasions and conducted two assessments based on a paper review of the Applicant's medical records.

7. The Respondent's assessments of the Applicant done on December 7, 2010 and May 17, 2012 each concluded that the proposed treatment plans were entirely reasonable and necessary. The assessments done on March 24, 2011 and July 14, 2011 concluded that the proposed treatment plans were partially reasonable and necessary. The paper review assessments done on August 29, 2011 and March 12, 2012 concluded that the proposed treatment plans were not reasonably necessary.

The Complaint and the Response

8. The Applicant complained:

- The Respondent repeatedly made negative comments about the Applicant's treating physiotherapist. The Respondent stated that his physiotherapist's "lack of information provided in reports is hurting [the Applicant] and [resulting in him] having to go through IME after IME";
- The Respondent submitted reports that were "riddled with mistakes" and she quoted him making statements that are "completely ludicrous";
- He believes that the Respondent's "opinion seems to be favouring [his] insurance company's bottom line";
- The Respondent failed to amend her report dated March 13, 2012 after additional documentation was provided to her; and
- At his assessment on July 14, 2011, the Respondent "suggested to [him] that it might be in the best interest for [her] to call [his treating physiotherapist] directly" for clarification of an OCF-18 form; however, the Respondent failed to follow up with the treating physiotherapist.

9. The Respondent responded to the areas of concern raised by the Applicant as follows:

- She advised the Applicant that some of the treatment plans submitted by his treating physiotherapist lacked an explanation as to why the proposed treatment was reasonable and necessary, and that this resulted in the Applicant having to undergo

repeated assessments. She meant no disrespect to the Applicant's treating physiotherapist and, in fact, complimented the progress the Applicant was making under his treating physiotherapist.

- The Respondent acknowledged that there were some minor inaccuracies in her reports but stated that she relied on information the insurer and the Applicant provided to her and noted that none of the inaccuracies was material to the conclusions in her assessment reports.
- The Respondent acknowledged that she does copy basic information from one report to another, citing that this is common practice, and thus avoids having to cover this prior ground each time.
- The Respondent stated that her reports were not biased in favour of the insurer and noted that her opinions were, for the most part, favourable to the Applicant.
- The Respondent stated that she was not aware of any further information being provided to her after the paper review of March 13, 2012 and noted that she was never asked by the insurer to complete an addendum report based on new information.
- The Respondent denied that she offered to contact the Applicant's treating physiotherapist and stated that it was not her usual practice to do so during the assessment process. She suggested that the Applicant may have confused this point with her willingness to speak with treating medical professionals *after* her assessment and report were completed.

The Committee's Investigation and Decision

10. The Committee investigated the complaint and decided to provide the Respondent advice about ensuring the accuracy of her reports and the need to ensure that her practice in this regard is appropriate and to take no further action.

JV v HAP, 2013 CanLII 59329 (ON HPARB) — 2013-09-20 http://canlii.ca/t/g0n2f

The Complaint and the Response

5. The Applicant complained about the Respondent's examination and conclusion. She took issue with many aspects of the assessment. For example, the Respondent concluded that the Applicant suffered from significant lower back pain several times a month while the Applicant asserted she experiences such pain every day. The Respondent noted a curvature of the spine in the IME report, which the Applicant complained was false. The Respondent concluded that the Applicant was not impaired by any accident related injury from continuing her schooling and the Applicant complained that this assessment was false.

6. In addition, the Applicant complained about the way in which the Respondent conducted the IME, alleging that the Respondent rushed through the assessment, failed to conduct a physical examination, and failed to consider x-ray and radiographic reports.

7. The Respondent provided a detailed rebuttal of the allegations, explaining the basis for each conclusion in his observations during the IME or the available medical records. He noted that all available records were reviewed, and that a physical examination was not necessary for the IME. Further, he denied that the IME was rushed, or conducted in an improper fashion.

MC v KE, 2013 CanLII 55435 (ON HPARB), 2013-09-04 http://canlii.ca/t/g0c3g

7. [...]The Respondent notified the Committee that, through the complaints process, she had discovered that Riverfront Medical Services (Riverfront), the company through which the Applicant's assessment was contracted, had changed the Respondent's report without her prior knowledge or consent.

9. As a result of its investigation, the Committee decided to take no further action, noting that the Respondent reported information that she considered to be accurate and that there did not appear to be any indication that the Respondent intentionally falsified factual information in the report or that she misrepresented information about the Applicant's abilities during the assessment.

10. However, the Committee did express concern about the information uncovered during the course of the investigation related to Riverfront having altered the Respondent's report. The Committee noted the "egregious" impact that these changes could have had on the Applicant's entitlement to benefits. In the result, the Committee decided to offer advice to the Respondent about the importance of ensuring that she personally reviews and approves any assessment report she completes prior to the report being issued.

Macdonald v. Sun Life Assurance Company of Canada, 2006 CanLII 41669 (ON SC),http://canlii.ca/t/1q596 2006-12-13

[1] In the course of this jury trial I ruled that Dr. Frank Lipson, who had conducted a defence medical of the plaintiff, not be permitted to testify as an expert witness on behalf of the defence. Dr. Lipson had testified that a medical report purportedly signed by him had not been signed by him. He stated that his signature stamp had been affixed to the report without his authority by an individual at Riverfront Medical Evaluations Limited (Riverfront) the company who had retained him to conduct the defence medical. [...]

[2] I have deliberated for a very long time before delivering these reasons. Although the action out of which the problem arose has long been concluded, this case raises vexing issues as to what role may be properly played by organizations such as Riverfront in the formulation of an expert witness' opinion.

[43] Twenty percent of their physicians conduct their assessments off site in which case the physicians will prepare their reports and send it to Riverfront by fax or other electronic means. Riverfront performs its quality control function and sends the report to the physician for comments if required. After consultation with the physician, the report will be prepared on Riverfront's letterhead and signed by the physician or as in the case at bar a signature stamp is affixed to the report, which is sent to the referring client.

[44] In many cases Riverfront has a signature stamp of the doctor, which the doctor authorizes them in writing to use. Dr. Levy produced a letter dated January 5, 2004 in which Dr. Lipson authorized Riverfront to utilize a signature stamp/electronic signature when issuing assessment reports – "when I am unable to directly provide my signature". The authorization provides that signature stamp would only be used "once I have approved the final copy of my report".

[88] It is stating the obvious that an expert's report delivered for the purpose of compliance with the *Rules of Civil Procedure* and the *Evidence Act* is an extremely important document. Anyone involved in the preparation of such reports must know that courts place a very strong reliance on the contents of these reports and that the proper administration of justice demands that these reports accurately reflect the opinion of the expert who has written them. The requirement in the *Rules of Civil Procedure* and the *Evidence Act* that the expert sign the report is intended to provide assurance that the statements in the report are those of the expert.

[100] Expert witnesses play a vital role in proceedings before the courts both in civil and in criminal matters. In personal injury actions in particular, the evidence of the expert witness may be the determining factor in the resolution of the plaintiff's claim In the case of health practitioners, section 52 of the *Evidence Act* provides under certain conditions, the report may be filed in place of the *viva voce* evidence of the health practitioners. The court is entitled to assume that the report represents the impartial opinion of the expert.

[101] In my view Riverfront in this case, went far beyond what can be considered a proper "quality control" function. While I am not prepared to find that they were motivated by a desire to assist the defendant, nonetheless I find their actions constituted an unwarranted and undesirable interference with the proper function of an expert witness.

[102] The function of an expert witness is to provide an independent and unbiased opinion for the assistance of the court. An expert witness' evidence should be and should be seen to be the independent product of the expert uninfluenced as to form and content by the exigencies of litigation.[2] This principle has often been cited with approval in our courts, and has been considered a factor to be considered in asessing the weight to be given to the expert's testimony. It has occasionally been treated as the basis for the disqualification of the witness entirely.[3]

[103] In my view any activity that may tend to detract from this all-important objective diminishes the integrity of the litigation and trial process and should be met with appropriate sanctions designed to send a clear message that such conduct will not be tolerated.

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