

OTLA RESPONSE TO THE DRAFT CTI GUIDELINE AND THE CTI GUIDELINE APPENDIX

The Ontario Trial Lawyers Association (OTLA) is comprised of lawyers who represent Ontario's injured. Our interest is in ensuring that the injured are able to access the benefits they require to return, as close as possible, to the life they lead before their motor vehicle collision.

OTLA does not support the adoption of The New Common Traffic Impairment (CTI) Guideline.

The Guideline reduces the treatment available to victims of motor vehicle accidents below critical levels. We estimate it will reduce treatment funding from \$3,500 to approximately \$1,000 per person (which is essentially 1% of what was previously available in 2010 to those who needed it, namely \$100,000 per person).

The guideline imposes an unscientific time limit of 6 months of treatment, curtailed further if the injured person improves during treatment. The studies proffered by the research team that informed the guideline demonstrate that 50% of those with CTI do not recover 1 year after an accident.¹ Accordingly, by capping treatment at 6 months, each year an additional 29,402 or more Ontarians will be left without funding for needed treatment.² Furthermore, Dr. Cote acknowledged on questioning that his team's research efforts were directed at determining the best care up to the point when 50% recover, not beyond. There is no scientific basis to cease treatment funding at 6 months. The research does not support it. Fifty percent of injured Ontarians is too large of a cohort to deprive of benefits.

¹ Journal of Manipulative and Psychological Therapeutics, Volume 32, Number 2S, "the preponderance of evidence indicates that, in adults, recovery of whiplash associated disorders is prolonged, with approximately half of those affected reporting neck pain symptoms 1 year after the accident.

² The Ministry of Transportation's 2012 Ontario Road Safety Annual Report shows that in 2012 there were 61,001 people injured in car accidents. 96.4% (58,805) of them suffered injuries that did not require admission to a hospital, and could be dealt with in the emergency room or by a family doctor. Fifty percent of 58,805 is 29,402 people.

The Guideline also imposes unduly restrictive exemption criteria. It only exempts those with a neurological disorder, autoimmune disorder, psychiatric condition or other serious pathology. Dr. Cote's research team reviewed presumed red flags, like pre-existing conditions, age, percentage of body in pain, baseline neck pain and headache intensity, and disability. They concluded that they could not reasonably predict who would recover and who would not at the 1-year mark from CTI. Accordingly, the best that science can offer, at present, is confirmation that a large cohort does not recover by one-year post accident. It is wrong to deny 50% of injury victims benefits simply because it cannot be predicted who will recover and who will not.

The guideline also reduces funding for those who start treatment several months following an accident. This is not supported by the research. For example, the guideline says "an insured person who begins treatment between 4 and 6 months post-accident may only access treatment set out in the persistent phase and not those recommended in the recent onset phase." So the injured person who waits gets 3 months of treatment instead of 6. The research team did not make this recommendation. The statistics encourage people to return to daily life. It does not make sense to deprive those who take a wait-and-see approach of the treatment they need when they don't recover.

The Guideline also provides insurers with the ability to deny treatment if it can be funded by alternate health care coverage (Part-K). This creates delay for the patient and increases paper work, adds to aggravation and creates the potential for conflict. It also provides the insurer with the potential to avoid any responsibility for medical rehabilitative costs for which the insured had contracted.

Dr. Cote's research team's findings did not deal with children, and expressly excluded application of their findings to children. Accordingly the Guideline should not apply to children.

The guideline also seeks to reduce funding for those who suffer mild traumatic brain ("mTBI") injuries. While many patients recover from mTBI there are many who have long lasting profound disability and who need significant care. Brain injuries are complex and each must be evaluated on a case-by-case basis. While it is good news that many recover, those statistics ought not be misused to deny treatment to those who are not so fortunate and in need of care. This is a serious point of concern for OTLA.

There is a discrepancy between the research of Dr. Cote's team and the guideline. However, OTLA's position should not be mistaken. OTLA has taken issue with Dr. Cote's team's recommendations, and expressed its concern in writing and upon questioning the research team on August 17, 2015 at the Financial Service Commission's technical meeting. Attached is a copy of OTLA's written submissions. What follows are significant comments made by the research team at the technical meeting, which have not been taken into consideration in the new guideline.

- The team's review was an investigation of best practices to the point in time when 50% of the injured recover and not beyond.
- The research team acknowledges 50% of those with NAD do not recover within the first year.
- The research team acknowledged that it could not predict, based on red flags, who would recover within 1 year from a NAD or not.
- Dr. Cote acknowledged that the number of treatment sessions recommended by his team was an average. Some clinical trials upon which the team relied provided patients with significantly more treatment than is currently recommended.
- The research team's cost-benefit analysis was predicated on one QALY equalling \$50,000, which the team acknowledged was arbitrary and at odds with the scientific literature that found that one QALY should equal approximately \$63,000 to be comparable with Australia, UK, and the USA.
- Dr. Cote remained steadfast that claim closure time equated to recovery time, based on his contemporaneous review of health records and claim closures, but admitted that his review did not segregate those who are in conflict with insurance companies seeking to obtain more treatment.
- The panel drafting the ERCTI report received feedback from two insurance companies during the drafting process, but no feedback or input from lawyers who represent injured people. The panel suggested that the presence of a retired judge on the panel was sufficient to represent the interests of injured people. However, upon questioning the judge via teleconference, he acknowledged that he had not practiced law for many years, and that he had no experience representing injured people in the context of the SABS.

OTLA remains concerned that the draft guideline does not address any of the concerns or issues that were raised by OTLA previously in writing, or verbally at the August 17, 2015 technical meeting. Although the draft guidelines are branded as creating greater assistance to injured people, the draft guidelines deprive injured Ontarians of treatment notwithstanding the premiums they pay for insurance coverage. In no single way does the guideline offer more assistance to the injured. It only takes it away.

In our view, the guideline should at a minimum:

1. Provide a mechanism to extend treatment, if after 6 months or 1 year a patient's symptoms persist, without the necessity of an ulterior diagnosis.
2. Strike a reasonable balance among (a) the cost of treatment (b) the amount of treatment (c) the duration of treatment and (d) the administrative simplicity of obtaining treatment.
3. Remove mTBI patients from the guideline.
4. Remove treatment for children from the guidelines.

We would be pleased to work with the policymakers to help strike a balance suitable to all.