Ontario Psychological Association (OPA) Response:

Anti-Fraud Task Force: Steering Committee Status Update

Aug 17, 2012

INTRODUCTION

The OPA has consistently advocated for a comprehensive and systematic approach to reduce fraud in the accident benefits system. Fraudulent individuals and organized crime divert funds that would be better spent providing services to legitimate claimants. Fraud also results in increased premiums. We are pleased to see that so much thoughtful effort has gone into addressing these problems.

Our response is from the perspective of psychologists who are regulated health professionals. An area of particular interest is the proposed licensing of health facilities. We also appreciate efforts to address other areas.

The OPA has been extremely concerned about the personal and professional risk of identity theft. Identity theft harms the reputation of the health professional and poses risks to patient care. We are aware of several disturbing examples. The OPA has also consistently advocated that health care should be provided by health facilities that are under the direction of health professionals. We are pleased to see that the Task Force recommendations address both of these issues which we believe are central to tackling fraud in this area.

The OPA has advocated for sound practices similar to those the Task Force has recommended. These practices support the regulated health professional's ability to be more accountable for their services and reduce the risk of fraudulent billing for services. These Task Force recommendations build on processes recently incorporated into the *The Revised Health Claims for Auto Insurance Guideline.* The OPA has worked with other stakeholders in the implementation of these requirements. We also note that the *Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims* stress the psychologist's responsibility to obtain informed consent for all proposals and services. This professional guideline is parallel to the directions provided by the Task Force regarding business practices.

The OPA notes that reduction in the overall benefit level has been one approach to reduce the attractiveness of accident benefits as a target for fraud and organized crime. We are aware of the very significant reductions made to the overall benefit package and to the dramatic lowering of accident benefits costs since the panel reviewed and commented on the 2006-2010 cost increases. However this broad approach creates additional barriers to rehabilitation and limitations for legitimately injured claimants. In contrast, we particularly support the recommendations that focus on identification and prosecution of fraudulent individuals and organized crime

Quoting the report, there has been a "startling and unexplained increase in claims for ABs from 2006 to 2010, primarily in the GTA". However, we note that all of the exhibits regarding cost trends in the Task Force report are based on pre-2010 reform data. This creates an inaccurate impression of the magnitude of the current problem and the scope of the solutions that may be required. Current data, which include a full year of claims experience, indicate that claims costs, frequency, and severity are significantly reduced.

The Task Force Report states that creating the minor injury cap on ABs may have helped to decrease overall AB. We also note that other measures, which were introduced as part of 2010 reforms, further contributed to dramatic reductions in claims costs (eg $2000 caps on assessments, insurer ability to deny benefit applications without paying for an IE, limits on attendant care, and discontinuation of housekeeping and care-giving benefits from the standard product).

We also note that recent arrests and prosecutions can be expected to be associated with reductions in fraudulent activity.

In keeping with this, the Task Force notes that it is more effective to disincentivize fraud than to prosecute it (p.36). When it comes to product design, this may have been accomplished by the 2010 reforms. While this may be helpful on one level, the OPA is concerned that an overall approach focused on funding and benefit reductions, as well as increased obstacles to access care for everyone, not only disincentivizes fraud, but also harms the legitimately injured. We have seen some evidence of this with increased denials of legitimate assessment proposals and treatment plans to ethical clinics adhering to high standards and provincial health professional guidelines for care. Any further changes proposed with the objective of reducing fraud must not create further limitations or barriers to care for legitimately injured claimants, or obstacles for legitimate providers, both of whom may presently be facing excessive challenges in their attempts to access and provide reasonable and necessary rehabilitation.

SPECIFIC TOPICS IN THE TASK FORCE REPORT

Privacy

The Task Force report states that insurers are pooling and sharing data.

A new company has been created to do analyses of new and suspicious claims and to forward these to regulators and investigators. The OPA is concerned about patient privacy and would like to know more about the industry data analytic pilot and recent development phase. Are insureds informed of this process? Are they aware of the content of items and data that are used for tracking, analyses, etc., that are being shared?

We have some additional questions and concerns about this proposal:

- Will claims continue to be adjusted while suspicious claims are being investigated?
- What are the criteria for determining suspiciousness in these analyses?
- Are individuals aware of how their data is being shared and analyzed?
- What data are shared between WSIB and auto insurers: business, personal?

The OPA agrees with the idea of sharing data with WSIB, if this is approved by the Information and Privacy Commissioner (IPC).

We also agree with the idea of partnering with Crime Stoppers to report potential fraud, again if the IPC agrees.

Regulated Health Professionals

The OPA fully supports the development of tools to reduce fraud including professional identity theft. We like the concept of the Professional Credential Tracker. We encouraged and fully participated with our regulatory college in the piloting of this tool.

- 14% of participants reported their credentials being used by clinics they didn't recognize.
- Nearly 2/3 said they would plan to run the report at least annually.
- Are these discrepancies being reported/investigated? Are they leading to arrests?
- We need to build upon this pilot to develop a readily accessible tool for all health professionals to be informed about the use of their professional identity in order that they may be more accountable for billings in their name.

Proposed licensing and regulation of health clinics

If there is to be an additional licensing scheme we support the inclusion of Insurer Examination (IE) facilities. We also support the distinction made between consideration of "business licensing" for purposes of business practices and the role of the health professional colleges providing "health professional regulation" regarding issues of professional competence and quality of clinical services.

The OPA supports the requirements in the proposed model for a regulated health professional director of any health facility with accountability for the "integrity of the business practices within the clinic", with limited exceptions of restricted licenses for facilities of unregulated providers. This health professional director model incorporates the support that is provided by the Health Professional Colleges in regulating health professionals including their business practices.

We agree that required attestations by the health professional director of a facility may be useful and we understand it is a parallel to the quarterly attestation requirement by the CEOs of the insurance companies. Prior to expanding this attestation process, it would be useful to have information about the functioning of the current process and the burden and utility to the system. We also note that it is essential to have further information about the reasonableness of the information that would be required to complete that attestation.

OPA Recommendations regarding the Regulatory Model for Healthcare and Assessment Facilities

The OPA appreciates the thoughtful work done by the Task Force and the soundness of the model proposed for licensing. However, given that many controls have been brought into place as a result of the 2010 reforms and *The Revised Health Claims for Auto Insurance Guideline,* the need may have been largely addressed.

Particularly regarding facilities directed by regulated health professionals; and business practices of regulated health professionals, it may be more reasonable to evaluate the effectiveness of the current reforms and determine if further coordination with the health professional colleges would address the remaining needs prior to implementing a further licensing scheme for regulated health professionals.

An additional layer of licensing for regulated health professionals would necessarily increase regulation and government burden.

Regarding facilities directed by regulated health professionals it may be reasonable to:

- See how numbers for industry post-2010 turn out

- See how less expensive and intrusive recently implemented measures fare. Some of these measures include:
    - Provision of detailed claims expenditure reports to the claimant;
    - Utilization of HCAI data reports and HCAI data base to identify outlier billing situations for further investigation;
    - Implementation of *The Revised Health Claims for Auto Insurance Guideline* which outlines a number of requirements and penalties for non compliance.
        - Some of the requirements include: plan approval numbers attached to invoices; limitation of invoicing frequency per treatment plan to a 30 day billing cycle; prohibition of submission of duplicate invoices; prohibition of submission of invoices for services that have not been approved;
        - The following is an example of the penalties: *A Participating Provider who repeatedly and/or deliberately submits duplicate OCF-21 forms through the HCAI system may be found by the CPA to be in contravention of the CPA's user terms & conditions (see Enrolment Of Users And Providers below). Such contravention may result in suspension, cancellation or revocation of the Participating Provider's access to the HCAI system.*
- Adopt and implement the additional business rules suggested in the Task Force report in an updated Guideline to further refine the expectations presently contained in the *The Revised Health Claims for Auto Insurance Guideline*
- Further develop the professional identity tracker

<u>UDAPs</u>
The OPA agrees with the Task Force recommendation regarding reviewing UDAPs and applying sanctions, where unfair and deceptive practices are proven to have occurred (after due process), not after alleged violations.

While not a focus of the Task Force, there is a need to confirm that these sanctions will apply to insurer behaviour, as well. The report doesn't mention insurer UDAPs enforceable with sanctions. When attempting to address appropriate business practice, consideration should be given regarding insurer business processes, for example, unreasonable denials without reasons and due process, unreasonable delays, late payments/ non-payments of approved plans and invoices by insurers. Does the UDAP also address this type of behavior?

<u>Transparency</u>
The OPA supports many of the recommendations made by the Task Force including requirements for transparency of clinic ownership.

The OPA agrees that all goods and services must be listed before asking the claimant to sign treatment plans.

We agree with requiring claimants to confirm attendance, receipt of goods and services billed.

We agree that claimants should be receiving itemized statements of all items that have been paid (i.e. cheques have been sent) from their AB accounts. We note that the present reports often lack sufficient details to provide useful information to the claimant. These reports must also clearly distinguish IE costs.

We agree that insurers should be more transparent, provide information regarding their selection of IE providers.

We agree with need for transparency from health clinics, IME companies, and insurers in terms of business practices, conflict of interest provisions, and disclosure of fees.

We agree that the new business to business reports are a potential tool which may help to identify any suspicious anomalies in billing/payment patterns. However, we need further evaluation to determine if these reports can be more fully utilized. We note that there is a disconnect between the insurer's view of expenses paid based on approved invoices, and health facility accounting based on funds received. This results in discrepancy due to the often significant delay between approval of the invoice and the receipt of payment.

Due Process

We want insurers to be able to report potential suspicious behaviour to police and regulators. We must ensure that potential, alleged fraud is subject to due investigative process before any determination (suspension of AB adjudication, non-payment of AB invoices, HCAI suspension, UDAP fines) or penalties are brought by any parties (police, insurers, regulators, colleges).

We note that procedural safeguards have been developed by the health professional regulatory colleges for investigating complaints.

Science- Application of Evidence Based Practice

We agree with the Task Force statement, "We support establishing new science-based approaches for treating and assessing injuries". In fact, in 2000 the OPA participated in the development and publication of the Psychology Assessment and Treatment Guidelines. Reflecting our commitment to evidence-based professional guidelines, the *Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims* have been revised in 2005 and 2010 to incorporate the most recent scientific evidence and literature. These Guidelines were most recently published in Psychology, Injury, and Law (2011) 4:89–126. The scientist/practitioner model of professional psychology supports that treatment must be based on the applicable evidence and adjusted to the individual patient need. We would welcome support for following evidenced based decision making regarding care of accident victims. However, we have found that many insurers do not consider these evidence based Guidelines when making their adjudication determinations.

Proposed second examination under oath

The OPA is concerned about subjecting victims to more examinations. Data indicates that claimants are already over-examined. We note while this is not an additional clinical examination, any additional request for the insurer to examine the claimant under oath must be subject to being reasonable and necessary.

Anti-Fraud measures in other jurisdictions?

The OPA agrees that we can learn from what has worked elsewhere. However we must also be mindful regarding the difference in context.

Towing
We do not have any specific comment re: towing industry, but support increased focus and mechanisms to address any issues of fraud, kick back, etc in this area.

CONCLUSIONS

If it is true that AB costs have decreased significantly, and the controls brought in by the 2010 reforms and the *The Revised Health Claims for Auto Insurance Guideline* have significantly reduced fraudulent activity; there may be less urgent need for further major changes at this time, particularly if it is costly, intrusive, or requires additional regulation.

While the suspicious increases in AB costs 2006 – 2010 may have been addressed, we continue to support active anti-fraud initiatives. We note that fraud is always fluid, changeable, and ongoing. The auto area has never had an active, systematic focus on fraud prevention, and the OPA supports maintaining this, even if initial concerns raised have been addressed. In addition to current improvements, we always need to anticipate how fraudulent providers or criminals will attempt to circumvent the system.

In conclusion, the OPA recommends, an evidenced based approach, evaluating the effectiveness of the present changes before engaging in more intensive measures that may not be needed at this time.

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