Ontario Rehab Alliance

51 Sophia Street
Peterborough ON
K9H 1C9

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

September 19, 2013

Maria Cece
Senior Manager
Automobile Insurance Policy Unit
Industrial and Financial Policy Branch
Ministry of Finance
95 Grosvenor Street, 4th Floor
Toronto, Ontario M7A 1Z1

Sent via email.

RE: ONTARIO AUTO INSURANCE DISPUTE RESOLUTION SYSTEM REVIEW

Dear Ms. Cece,

The Ontario Rehab Alliance (the "Alliance") welcomes this opportunity to provide input to the Honourable J. Douglas Cunningham's review of Ontario's dispute resolution system.

Our association represents approximately 90 companies representing about 3,500 health care providers including physiotherapists, occupational therapists, speech language pathologists, chiropractors, psychologists, rehabilitation therapists, social workers, nurses, personal support workers and case managers. It is these individuals who are the primary providers of healthcare and rehabilitative services to Ontarians who are injured in automobile accidents. Ontario Rehab Alliance members help those injured in motor vehicle accidents regain function and dignity in the aftermath of the 65, 000 crashes which affect Ontarians every year.

Our observations are focussed on two aspects of the current dispute resolution (DR) system and reflect our perspective as providers of healthcare services to victims.

1. Timeliness of the DR process
2. Increased and Unnecessary Pressures on DR

1. Timeliness of the DR Process

We commend the improvements in the current dispute resolution process which have resulted in a substantive reduction of the longstanding backlog of cases awaiting mediation. Treatment plans (OCF-18s) and the Application for Attendant Care (Form 1), submitted by healthcare providers are time sensitive applications. Delays in approval result in assessment and treatment delays that can have dire consequences for injured parties. Prompt assessment and timely, appropriate treatment has been clinically demonstrated to expedite rehabilitation and recovery. Past delays of many months in duration while awaiting mediation resulted in undue harm to those injured and eroded confidence in the system and the Accident Benefit scheme.

The current average of 60 days wait for mediation is acceptable, though shorter wait times will always be more advantageous. If this pacing can be maintained or improved upon we feel that the current DR system can regain the faith of stakeholders.

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Triaging Cases Awaiting Mediation

We are not aware of how the current mediation wait list is administered.

***Recommendation**: We suggest that there may be opportunities to "triage" the cases awaiting mediation to mitigate the negative impact on those who situations are particularly dire and time sensitive.*

'Leapfrogging' Mediation to Arbitration

We understand that the Review is particularly interested in comments regarding maintaining Mediation as a mandatory step in the DR process. We presume that this inquiry results from impact of high numbers of failed mediations that must then proceed to arbitration for resolution. In the interest of streamlining and expediting the DR process we would support exploration of this system renovation.

***Recommendation**: We suggest that key and informed stakeholders, such as the Ontario Trial Lawyers Association (OTLA) and the Insurance Bureau of Canada (IBC) may be able to arrive at a protocol to guide selection of such exceptions to the rule of mandatory mediation. Ideally, other stakeholder would be provided with an opportunity to provide input to whatever proposal might emerge.*

2. Increased and Unnecessary Pressure on DR

The Ontario Rehab Alliance members have observed and reported what they view as increased and unnecessary pressure on DR, arising chiefly from two aspects of the current system.

Significantly Increased Denial Rates

We have seen a dramatic increase in denial rates since the 2010 cuts to Accident Benefits. This observation has been substantiated by the findings from a survey conducted by the Alliance and the Coalition of Health Care Provider Associations in September 2011. The denial rate of applications for the assessment and treatment of motor vehicle accident victims, (i.e. Section 25 Assessment OCF 18s and Treatment Plan OCF 18s), in the period after September 1, 2010 had increased by 158% and 141% respectively as compared to the period prior to September 1, 2010. Specifically, the average reported rate of denial (comparing pre‐Sept 2010 period to post‐Sept 2010 period) for Assessments had increased from 12% to 31% and for Treatment from 12% to 29%.

Insurers, usually without medical training, frequently choose to deny assessment and treatment requests without seeking out an Independent Exam (IE). With the absence of IE time lines, (which were removed from the process in 2010) insurers are in effect incented to delay IE's for as long as possible. Another tactic often employed by insurers is choosing to deny funding for progress reports prepared by treating providers to limit the providers' ability to document rehabilitation procedures and outcomes, making it easier to deny further treatment.

Poorly Documented Denials

Since the 2010 elimination of the mandatory IE and rebuttal process, we note that increased numbers of insurers are not supplying the "medical and other reasons" for denying assessment and treatment requests, despite reminders from FSCO that they are expected to do so. This leads to a lack of confidence in insurer adjudications, pushing plaintiff lawyers to initiate a dispute. Poorly documented denials result in increased time and costs for insurer examinations and mediations when each side must

perform more comprehensive investigations into broader issues, rather than being able to focus on the insurer's particular concern.

Sub-Par Independent Exams

Along with a number of other stakeholders we believe that sub-par Insurer Exams put increased and unnecessary pressure on the DR system. Insurer exams, when properly done and well regarded, play a vital role – providing insurers with insight and expertise to assist them in making difficult decisions from a layperson's perspective and, in so doing, helping insure that benefit dollars are well used.

However, it is vital that all parties can respect the findings of IEs. Numerous arbitrations have raised concerns about the current state of affairs.

Recommendations:

- Insurers must be held to account and sanctioned for failure to provide proper justifications for denials and that qualified IEs (see below) be reintroduced into the process to minimize the number of cases proceeding to DR.

- Guidelines should be developed to assist insurers in identifying 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).

- Standards for IE assessor qualifications and procedures must be developed. This requirement was recommended as part of the last round of reforms, but has not been acted upon. 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 which we support. For example, IE assessors should be required to have a minimum number of years of 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 whom they know to be unqualified or biased. There are many 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 as well as putting pressure on the DR system.

- 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)

- In parallel with recently enacted requirements for medical-legal assessments, IE assessors should sign a similar Acknowledgement to Form 53 requiring the assessor to pledge adherence

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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 tends to spark 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.

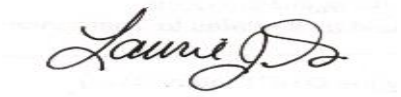
- Allow rebuttals in response to IE reports

- Re-establish and enforce timeframes for referral and completion of IEs

In sum, we continue to applaud ongoing improvements to the DR process to improve the experience of accident victims and increase all stakeholders' faith in the fairness of the system.

The Ontario Rehab Alliance would welcome an opportunity to be further involved in DR enhancement efforts.

Sincerely,



Laurie Davis, Executive Director