



**Ontario Psychological Association Response:
Report on the Five Year Review of Automobile Insurance
March 31, 2009**

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Ontario Psychological Association Response re: Report on the Five Year Review of Automobile Insurance

Introduction and Executive Summary






The Ontario Psychological Association (OPA) appreciates the opportunity to present our responses to FSCO's recommendations for auto insurance reform. As consumers and health professionals, we appreciate the difficulty inherent in the task of balancing the need to maintain an auto insurance system that provides affordable premiums for consumers while protecting those who are injured in auto accidents.

We note that many of the recommendations are intended to enhance consumer protection, however, the OPA is concerned that some of these recommendations will instead cause harm to seriously injured accident victims. Our greatest concern is that seriously injured patients will exhaust the FSCO recommended \$25,000 benefit limit quickly, and be offloaded to the OHIP system, which does not provide funds for ongoing rehabilitation in the community. While these recommendations may have been well intended, some of them do not meet the goal of protecting injured consumers.

We provide below in the body of this response more detailed comment on recommendations that are particularly relevant for patients with psychological impairments, including brain injuries.

We also hope to have the opportunity to participate in the recommended processes to address: the expansion of the Pre Approved Framework, review of the catastrophic impairment criteria, development of standards and qualifications for third party examiners, review of specific regulations to implement the recommendations, and any other areas where our particular expertise and health professional perspective may help to facilitate sound policy and implementation mechanisms.

The OPA recommends the following:

-  The OPA recommends FSCO hire a forms consultant.
-  The OPA recommends multi-stakeholder consultation to review the catastrophic impairment definition and determination processes
-  OPA recommends that assessment costs remain distinct from medical and rehabilitation benefit limits
-  OPA recommends fees for psychological assessments be determined by profession-specific, evidence-based guidelines, and hourly fees as per FSCO's PSG. (See appendix *OPA GUIDELINES FOR AUTO INSURANCE CLAIMS* assessment tables)
-  OPA Recommends if caps are introduced for any assessment fees, assessments for catastrophic impairment determination be excluded.

- ✚ OPA recommends allowing in home assessments when the patient's condition precludes in-office assessment and/or the focus is in-home functioning
- ✚ OPA supports joint development of standards for third party examinations and assessor qualifications
- ✚ OPA recommends that psychologists with appropriate training and experience in diagnosing psychological and cognitive impairments conduct catastrophic assessments. We further recommend development of standards for determining qualifications for conducting catastrophic assessments.
- ✚ OPA recommends all assessment costs, including insurer examinations be based on professional assessment guidelines and hourly fees.
- ✚ The OPA recommends increased insurer discretion regarding the utilization of IEs and paper reviews
- ✚ The OPA strongly recommends that rebuttal examinations be maintained.
- ✚ The OPA recommends maintaining direct patient access to psychologists as the most effective model from both clinical and cost perspectives
- ✚ The OPA recommends to maintain direct access to the Pre Approved Framework (PAF)
- ✚ The OPA recommends that psychologists be considered a PHP of choice for patients with brain injuries and psychological impairments
- ✚ OPA recommends that while there is no conflict of interest in providing assessment and treatment to one's own patient, perceived concerns regarding conflict of interest in referrals should be addressed.
- ✚ The OPA recommends that the PHP provide direct services as well as referrals to other services and service providers
- ✚ The OPA recommends that the PHP be part of electronic submission process i.e. HCAI
- ✚ The OPA cannot support proposals for "case management" for patients who do not have catastrophic impairments, or utilization of insurer case managers.
- ✚ The OPA strongly recommends retaining the \$100,000 basic benefit level.
- ✚ While the OPA recommends exploration of further elaboration of the PAF, we stress that it is clinically inappropriate to rely on initial diagnosis and participation in the PAF to limit access other benefits and to post PAF treatment.
- ✚ OPA supports the increase in the income replacement benefit
- ✚ OPA supports annual review of the reimbursement rate for travel as well as reconsideration of the exclusion of the first 50 kilometres per round trip as this may pose a financial burden on those who are living with reduced income due to their accident injuries.
- ✚ OPA recommends that housekeeping, home maintenance and care giving remain part of the basic benefits package.
- ✚ The OPA supports the removal of the definition of serious and permanent impairment that added unnecessary complexity
- ✚ The OPA recommends amending the cap on expert reports.
- ✚ The OPA recommends specialized training for adjusters who work with accident victims with serious injuries and would welcome an opportunity to participate in educational programs.



The OPA would welcome the opportunity to work together with consumers and insurers to develop educational endeavours and deliver programs regarding treatment and outcomes.

OPA Response to FSCO Recommendations

FSCO Recommendation #3: hire a forms consultant to assist in simplifying the application process and forms.

While we appreciate the need to collect relevant information in order to inform appropriate decision-making, our members have found that accident victims with psychological impairments and brain injuries often find completion of the required forms a significant challenge, especially if English is a second language for them. There are many reasons for this, but it has been our experience that some patients find the process so overwhelming that they simply abandon their attempt to seek benefits. The stakeholders must determine which information is truly relevant. A forms consultant may assist in development of more user-friendly forms (e.g. possible electronic submission of forms).



The OPA recommends FSCO hire a forms consultant.

FSCO Recommendation #10: consultation to amend the catastrophic impairment definition and ensure fairness for the most seriously injured accident victims.

OPA members have considerable experience with the current definition of catastrophic impairment in their role providing psychological services to seriously injured crash victims and as catastrophic impairment assessors. Our membership has significant concerns regarding potential discrimination against accident victims with psychological impairments and brain injuries in some proposals regarding catastrophic impairment criteria. We agree with FSCO's goals to reduce complexity, protect consumers, and ensure fairness and non-discriminatory access to appropriate benefits for the most vulnerable and seriously injured. Fair, valid, non-discriminatory methods to determine whole person impairment are available and should be considered in the consultation process. We welcome the opportunity to provide more data regarding these methods during future consultation.

✚ The OPA recommends multi-stakeholder consultation to review the catastrophic impairment definition and determination processes

FSCO Recommendation #11: include assessment costs within limits for medical and rehabilitation benefits.

Our membership cannot support FSCO's recommendation to include Section 24 assessments within the envelope of available funds for medical rehabilitation benefits. Such an action will reduce the funds available for both assessments and for other goods and services, leaving less funding available for treatment and rehabilitation to address the injured person's needs. While we understand that there may be some areas where assessments appear to be over-utilized in the current system, data has not yet been presented that allows for analysis of this problem. We must re-iterate that there is no data to determine which specific types of assessments are being over-utilized, or by whom. There is no way to conclude that including assessments in the medical and rehabilitation benefit will actually reduce overutilization of assessments of any kind. It will, however, reduce the amount of benefits available to injured people. This will disadvantage the most vulnerable and seriously injured disproportionately, as their benefits will be used up more quickly by the multiple assessments that they require to plan treatment and rehabilitation in multiple domains. This is not consistent with FSCO's goal to protect consumers or ensure fairness in the system.

✚ OPA recommends that assessment costs remain distinct from medical and rehabilitation benefit limits

FSCO Recommendation #12: "the fee for completing forms including any assessment required to complete the form should be capped at \$200. The cost of all other assessments should be capped at \$2,000".

We note some confusion around this recommendation. It is unclear what is meant by referring to an assessment to complete a form. We also note that guidelines for assessments and limits for hourly professional fees and form completion currently exist.

In reviewing this FSCO recommendation, we note that forms are completed after many assessments. We understand that the majority of assessments that do not result in a form are those where it is concluded no treatment is required or no disability exists. Thus, we recommend that all assessment fees should be based on professional time as per professional guidelines and hourly fees according to the FSCO published Professional Fee Schedule

(PSG). It is not reasonable to determine the cost of the assessment based upon whether or not a form is completed subsequent to the assessment.

Assessments of more complex conditions and/or those that require more time cannot be subject to a \$200 cap even if they result in completion of a form. To provide funding for the clinical assessments needed to apply for treatment and other benefits, insurers must continue to pay reasonable fees for reasonably required assessments.

✚ The OPA recommends that assessment fees remain distinct from fees for form completion; clarification is required to ensure that completion of a form subsequent to an assessment does not limit the assessment fee to \$200.

The need for more comprehensive assessments is particularly relevant to patients with psychological impairments, including those resulting from brain injuries. By their nature, these impairments are not as readily observable as many physical impairments. Accurate diagnosis and formulation of the patient situation is necessary to plan effective treatment. Most often this involves extensive interviews, observations and administration and interpretation of psychological tests. We do not agree that any assessments should be subject to a fee cap.

The FSCO proposal of a \$2,000 cap for “other assessments” is arbitrary and inadequate for assessment of some patient conditions. The OPA is very concerned that this proposed cap would disadvantage those with the most complex injuries, including those with psychological impairments and brain injuries. Neuropsychological, psycho-vocational and psycho-educational assessments often require several interviews and an extensive battery of standardized tests to accurately diagnose impairments and identify residual capacities to be utilized in treatment/rehabilitation planning and disability management. Because we foresee that FSCO’s proposal #12 to cap assessment fees will disadvantage those with complex injuries, including brain injuries and psychological impairments disproportionately, we must reiterate our opinion that this proposal is entirely inconsistent with FSCO’s stated goals for fairness and consumer protection.

Current regulations require that assessments be reasonable and reasonably required. Such reasonableness can be determined by using evidence-based guidelines for assessment interventions and FSCO’s PSG for hourly fees. Therefore, it is our recommendation that rather than a general cap that discriminates against those with the serious and complex injuries, it is more appropriate to impose a requirement that fees for assessments be based on profession-specific, evidence-based assessment guidelines and published hourly fees.

The Ontario Psychological Association has guidelines for the profession that are evidence-based and reflect best practices. These guidelines provide specific direction regarding the component procedures and hours required to complete an assessment and propose treatment, dependent on the type of assessment proposed and individual patient factors. The first *Psychology Assessment and Treatment Guidelines* were created by the OPA, subjected to peer-review, and accepted and published by FSCO on March 31, 2001. These were updated

in 2005 following a rigorous review of the scientific literature, relevant arbitration decisions, as well as applicable regulations, laws, and professional ethical standards. The foundation and fundamentals of the 2001 guidelines were preserved during this process. The guidelines were subjected to peer-review, and were accepted and published by the OPA on January 11, 2005. Psychologists in the province are expected to use these guidelines when proposing and reviewing assessment and treatment plans.

This Guideline based approach to fee determination provides cost control and is responsive to the individual patient situation. We note \$2,000 will encompass some patient presentations, however, for more complex patient situations and/or assessments that require extensive formalized testing the cap is not sufficient to carry out the assessment. It is our opinion that profession-specific, evidence-based guidelines can and should be used to determine the reasonableness of assessment costs, rather than an arbitrary cap that does not consider complexity of impairments and patient needs.

In the auto insurance context it is necessary to address causality and credibility, which increases the time reasonably required to complete an assessment. Access to benefits under the no fault system requires that the impairments be a result of a motor vehicle accident. Thus, unlike most other clinical contexts, often a very time consuming component of the assessment is determination of the specific causality of the impairment and attribution to the specific event of the motor vehicle accident. This critical question may be a source of great controversy especially in patients with significant pre-accident medical history or co-occurring disorders. These questions are even more challenging to address than when the impairment is not an uncomplicated physical injury where the causal link to the accident is usually more obvious. There may also be issues regarding the credibility of the complaints presented by the patient and questions of malingering or exaggeration. In most other treatment contexts, this question does not require significant attention. Questions of exaggeration or credibility are more challenging and time consuming to address than in the physical examination where the impairment may be more readily diagnosed relying on objective signs and symptoms.

It has been suggested that the WSIB offers a bench-mark for processes and costs of assessments. However it must be noted that the nature of the population, injuries and especially system requirements vary significantly. WSIB assessors are not expected to address issues of causality or entitlement as these are addressed prior to the referral for the assessment. (As noted above addressing these issues may be the most time consuming aspect of the assessment in order to determine if the impairments are a result of the accident.) In addition, WSIB assessors are not expected to appear in mediation, arbitration or court to give testimony and be cross-examined on their reports and opinions. The OPA also points out the comparison to WSIB published fee schedules may be misleading. We understand that the four hours allowed to initiate treatment is not a formal assessment but is only intended to be a screening. In addition, the psychologist may request and be approved additional time. Similarly, neuropsychologists who conduct these examinations report that the WSIB often approves and pays hours required by the psychologist according to the OPA Guidelines rather than capping at the 12 hours described WSIB website.

✚ OPA recommends fees for psychological assessments be determined by profession-specific, evidence-based guidelines, and hourly fees as per FSCO’s PSG. (See appendix *OPA GUIDELINES FOR AUTO INSURANCE CLAIMS* assessment tables)

Assessments to determine catastrophic impairment are especially controversial, complex and require a high level of training and expertise. There is often significant disagreement on questions of causality and credibility requiring reviews of extensive medical files and comprehensive examinations. Often it is necessary to review a file that may be over a thousand pages long to review questions of causality and entitlement. The critical question often involves distinguishing between pre-existing vulnerabilities and co-existing disorders from conditions that result from the MVA. This cannot be determined solely by examination of the patient.

These assessments are not comparable to the NEL (Non Economic Loss) exams in the WSIB. In the NEL examination, the examiner generally provides a measurement of a single specific impairment. The NEL examiner does not provide a rating of total impairment, and does not offer an overall opinion. Entitlement has been determined prior to the examination, and impairment rating is done by others subsequent to the examination. It also appears that the NEL examinations generally do not address neurological, and mental and behavioural impairments.

In contrast, catastrophic impairment assessments must provide a whole person impairment rating (WPI) to determine if the person has a total impairment of 55% or more. This WPI rating may involve several body systems requiring expertise of various medical specialists and other specialists, for example psychiatry, neurology, ophthalmology, dentistry. In addition, it may be necessary to address questions of cognitive impairments due to brain injury and mental and behavioural disorders. Often, no single health professional has the expertise necessary to complete the range of examinations required. These component examinations must be integrated to produce an opinion as to whether the person has a catastrophic impairment. Therefore it is essential that there be sufficient funding for a team of expert examiners when indicated by the conditions to be assessed.

We note that the IBC recommends in their submission that, *“Insurers are not obligated to pay more than a total of \$15,000 for an assessment or group of assessments to determine whether catastrophic impairment has been sustained for the purposes of qualification for Accident Benefits”*. While we can agree that the IBC proposal would be adequate for many catastrophic impairment assessments, we are aware that it would not be adequate to address those more complex and controversial assessments requiring an extensive file review and additional assessors beyond a basic team.

✚ OPA Recommends if caps are introduced for any assessment fees, assessments for catastrophic impairment determination be excluded.

FSCO Recommendation #14: limiting in home assessment to attendant care and home modifications.

A subset of patients seen by psychologists suffer with severe physical and cognitive limitations and may be unable to leave their homes or institutional placement. In these situations, assessment and treatment cannot be provided unless it is in the patient's home. In addition, some assessment questions and treatment interventions are specifically directed towards the person's ability to function in their home environment and are most effectively conducted in that setting. Again, we believe that limiting home assessments would disproportionately disadvantage those patients who are unable to leave their homes because of their injuries. We do not think that this is consistent with FSCO's goals for consumer protection and fairness.

✚ OPA recommends allowing in home assessments when the patient's condition precludes in-office assessment and/or the focus is in-home functioning

FSCO Recommendation #16: health care professional associations and the insurance industry to jointly develop standards for the delivery of third party examinations and qualifications for assessors.

The OPA has identified concerns regarding the quality of some insurer examination reports as problematic for patients and a potential cost driver for the system when they contribute to disputes, rather than resolving them.

We believe that clarity about the qualifications and standards for insurer examiners will contribute to a higher quality of examinations and reports. We would be pleased to engage in such a process to ensure that higher quality service is delivered.

✚ OPA supports joint development of standards for third party examinations and assessor qualifications

FSCO Recommendation #17: restrict the conduct of catastrophic impairment assessments to practitioners with appropriate training and experience

It is our opinion that further clarification and consultation is required in order to determine which practitioners have the qualifications to do this very challenging work. It is noted that health professionals from a variety of disciplines including psychology have the training and experience to conduct catastrophic impairments.

We recommend that a process similar to that described in FSCO recommendation #16 for multi-stakeholder development of standards and qualifications of third party assessments be considered for catastrophic assessments and determination. It must be clarified whether certain educational programs will be mandated and if a roster of health professional experts with the appropriate education and training will be developed. If such a roster is created, criteria for inclusion and exclusion must be considered.

✚ OPA recommends that psychologists with appropriate training and experience in diagnosing psychological and cognitive impairments conduct catastrophic assessments. We further recommend development of standards for determining qualifications for conducting catastrophic assessments.

FSCO Recommendation #18: cap insurer examination fees to \$2000

Please see our discussion of FSCO's recommendation #12 to cap fees and assessments to complete forms, and OPA Guideline assessment tables in the Appendix. It is our opinion that all psychological assessments, including insurer examinations, should follow OPA Guidelines and the PSG. Adjusters and others should be able to refer to the Guidelines and PSG to determine reasonableness of assessment costs. We believe that other profession-specific, evidence-based guidelines should also be used in this way as reflecting best practices and the standard of care for that profession, in their communities. Limiting assessments for benefit eligibility and determination is not fair to the accident victim or to adjusters who require high quality, appropriate information to aid them in decision-making. Thorough and sound insurer examinations are cost effective for the system as a whole as they may provide more credible opinion on the matter in dispute.

✚ OPA recommends all assessment costs, including insurer examinations be based on professional assessment guidelines and hourly fees.

FSCO recommendation #19: increase insurer discretion in requiring IEs.

We are familiar with the unnecessary distress and delays caused to injured people when required to attend unnecessary IEs. We are also familiar with anecdotes of repetitious assessment and treatment proposals that are created without patient knowledge or consent, that do not fall within current standards for accepted practice, that insurers are nevertheless required to send to paper review or IE, incurring significant unnecessary cost to the system and confusion for the patient.

It is our opinion that insurer use of profession-specific guidelines and the PSG, together with increased discretion to approve and deny without IE review might reduce the current need for excessive IEs. This will reduce the unnecessary costs to insurers as well as the delays, confusion, and distress for patients that are associated with excessive and unnecessary examinations.

Further reduction of complexity and reduction of the burden and cost of the IEs might be accomplished by greater insurer latitude for when the IE might be conducted by paper review, rather than direct examination. Removing the specific criteria for when a paper review IE may be utilized will also reduce unnecessary complexity in the regulations.

✚ The OPA recommends increased insurer discretion regarding the utilization of IEs and paper reviews

FSCO recommendation #20: removal of rebuttals

It is our opinion that rebuttals provide a critical check and balance in the system, and are especially critical for catastrophic impairment determination process.

The rebuttal examination may be the only opportunity that the insured person has to have a health professional specialist review and explain the IE report as the IE examiner does not provide feedback to the claimant. The FSCO report states that the claimant would continue to have access to FSCO's dispute resolution services. However, without the rebuttal examination, the claimant may not be in a position to determine whether they have a basis to dispute the decision of the insurer to deny a benefit based on the IE. The rebuttal allows the insured person the ability to obtain an informed opinion about whether there are significant flaws in the IE and a basis to contest the opinion, or if they should accept the decision.

We do not have data that allows us to comment on how frequently the rebuttal examinations are being utilized, how often they result in an immediate reversal of a decision, or their utility in mediation or arbitration. However, OPA members have considerable anecdotal experience regarding the effectiveness of rebuttals in altering insurers' decisions regarding approving assessments, approving treatment, continuing disability payments, and approving catastrophic impairment applications. We are aware of the critical role rebuttals play in mediation and arbitration of disputes.

Effective limits already exist on the utilization and costs of rebuttal examinations. For example, there is no payment for a rebuttal to a denied assessment, even though these are frequently required to facilitate patient's access to needed assessments. It is our experience that accident victims rarely obtain multidisciplinary disability assessments initiated by their own health professionals, as a result, they tend to rely on the modest funding available for disability rebuttals to evaluate both the clinical information and the methodology of the opinions rendered by multidisciplinary insurer assessors.

We anticipate that if other measures are taken to improve the quality of the IE, the use of the rebuttal may decrease. However, it will still be a vital mechanism to address those situations, in which, for example the IE has failed to consider relevant factors or made an error in analysis. Such errors and failures have a significant effect on patient access to benefits. Rebuttals are the only means for patients to have such errors addressed and considered in reviewing their applications for benefits. Protecting consumers and ensuring fairness requires that errors can be reconsidered quickly, without initiating the next stage in dispute resolution that causes further costs, delays, and distress.

We must note our particular concern that rebuttal assessments be maintained for catastrophic determination. The rebuttal is often the only assessment specific to catastrophic impairment determination that is funded for the accident victim when catastrophic impairment is being considered. If the injured person has a catastrophic impairment application completed by a single treating health professional, the insurer may respond to the application with a multi-disciplinary insurer examination. If the insured person does not agree that the insurer examination is an accurate assessment of their condition, the rebuttal provisions are essential for the insured person to have a balanced opportunity to diagnose and rate their impairments and determine if they will dispute the insurer's opinion. Continued funding for rebuttal examinations is critical to provide balance in the catastrophic impairment determination process.

✚ The OPA strongly recommends that rebuttal examinations be maintained.

FSCO Recommendations #15 and #21: require primary health professional (PHP) (in most cases a family physician) referral for completion of a psychological assessment and treatment plan applications.

The FSCO recommendation of a “Primary Health Professional (PHP)” to “manage, oversee, coordinate, and direct” the patient’s rehabilitation appears to have been made as a method to decrease perceived duplication of services and enhance the coordination of an injured person’s care. The FSCO recommendation indicates that the PHP is not a “gatekeeper”, per se, but is responsible to make referrals for assessments and treatment to the most appropriate services or service providers. The health professional receiving the referral is responsible to develop and submit the assessment request or treatment plan directly to the insurer for approval without need for certification by the PHP. FSCO recommends that in most cases family doctors fulfill this role. The FSCO proposal suggests that patients who do not have a family physician could rely upon walk-in clinics and other ambulatory care facilities to fulfill these responsibilities.

While the intention may have been to reduce duplication and improve service, we find this recommendation to be regressive and out of keeping with current attempts by this government to streamline health care, reduce wait times, and increase direct access to health providers.

Most non-physician health and rehabilitation services are not funded by OHIP. This includes most services provided, for example, by dentists and psychologists. While physicians may refer to physiotherapists and medical specialists routinely, Ontario citizens generally access services such as dental and psychological care directly. We note that similar to dental services, no referral is required to access most psychological services that are payable through private Extended Health Benefit insurers. In these cases psychologists are recognized as primary mental health practitioners with the legal authority to communicate a diagnosis. The psychologist is responsible to the patient to determine if assessment is required, diagnose impairments, and prescribe and provide treatment.

In many instances, direct patient access to a psychologist is the most efficient and cost-effective way to deliver clinical assessment and treatment services. Patients may receive a recommendation to seek psychological assessment and treatment from another health professional, or, given increased public awareness, many patients self-determine the need. While, some patients may consult their family physicians before making an appointment, many do not discuss it at all. Referrals often originate because a specific psychologist or organization is recommended by a friend, family member, another health professional, or a member of the larger community. The OPA maintains a referral service to help patients identify a psychologist with appropriate expertise in their locale.

Direct access to psychologists is especially important, since many patients feel unable to discuss their psychological problems with their physical treatment providers, including their family physicians. We must also note that most family physicians simply do not have the time

required to hear about psychological complaints; if physical treatments are being provided, and only one or two complaints are allowed for discussion at a visit, it is unlikely that either patient or physician will initiate a conversation about psychological complaints that may prompt a strong emotional reaction and require more time to resolve than the appointment allows. Given the continuing social stigma associated with psychological disorders, many patients simply would not seek psychological treatment if required to disclose these concerns to their family physician prior to accessing a psychologist. On the extreme, some patients even refuse to provide consent to communicate with their family physicians. In the context of providing physical treatment to seriously injured MVA victims, there may not be time to address these more sensitive and often time-consuming concerns. Patients often must overcome their own reluctance to acknowledge and address psychological problems. It is counter productive and would create a further barrier to require the accident victim to first disclose these issues to another health professional prior to being able to engage with a psychologist. We note that often subsequent to involvement with a psychologist, the patient is more able to inform their family physician of their concerns regarding their psychological functioning. The psychologist may collaborate with the physician regarding any indications for psychotropic medications.

We note that Premier McGuinty and Health Minister Caplan have recently announced plans to enhance the scopes of practice of several health professions. One stated purpose of the enhanced scope of practice is to ease long waits for health care. The Premier stated, “changes should shorten wait times and enhance access to care” and included the example, “people needing a prescription refilled would be able to make one trip to a pharmacist, instead of two trips; one to a doctor and then one to the pharmacist”. Minister Caplan added that, “a lot of this seems very common sense”. We note that FSCO’s recommendation of physician referral is completely contrary to this move toward more streamlined and direct access to services. Introducing a new requirement for accident victims to see their family physician in order to receive a referral for assessment or treatment by a psychologist where none has been required before creates bottlenecks, increases barriers and wait times, adds additional unnecessary burden to the public system, and does nothing to streamline or improve access to service.

The OPA recommends maintaining direct patient access to psychologists as the most effective model from both clinical and cost perspectives

Patients currently self-refer to the Pre Approved Framework (PAF) provider of their choice for direct and timely access to these services. No other referral is necessary. This PAF health professional functions in the role similar to that described for the PHP in FSCO’s recommendation. The PAF Guideline states, “*Providers who are able to deliver services within this Guideline are any health practitioners, as defined by the SABS, who are authorized by law to treat the injury and who have the ability to deliver the interventions included in this Guideline. The health practitioner may also coordinate the provision of services by other regulated health professionals, or may directly supervise the provision of services to the insured person by one or more other health providers*”. The health professional disciplines listed for this role in the PAF include: Chiropractor, Dentist, Nurse Practitioner, Occupational Therapist, Optometrist, Physician, Physical Therapist, Psychologist, and Social Worker. We

note that insurer pre-approval is not required for the assessments and treatments that are contained within the PAF. The OPA views this as a direct access model involving coordination of multiple providers and treatment modalities that is effective without requirement of involving the family physician.

✚ The OPA recommends to maintain direct access to the Pre Approved Framework (PAF)

It is neither necessary nor cost effective to limit the role of the Primary Health Practitioner (PHP) to the family physician. It certainly is not efficient when psychological impairments are the primary presenting feature to be addressed. As a result, it is our suggestion that if the government finds it to be necessary to adopt a PHP model for non-PAF and post-PAF assessment and treatment, the qualifications and role of the psychologist to carry out this PHP function particularly where psychological factors predominate be incorporated.

Psychologists are highly trained, think systemically, and consider the interaction of psychological and physical factors on our patients' health and functioning. Psychologists currently function as primary health practitioners with their (MVA and non-MVA) patients, identify unmet needs and facilitate referrals to other providers, including physicians. Neuropsychologists, Rehabilitation Psychologists, and Health Psychologists frequently function as a team leader for their patients. They are trained to consult, coordinate, and refer appropriately within a health care team model. If a PHP model is adopted to provide more integrated services, the OPA suggests that psychologists are qualified and experienced to carry out this role. Therefore, the patient should have the option to select a psychologist to be the PHP when they have psychological impairments including brain injuries. (We note that other health practitioners may also be qualified and experienced to provide this role for patients with impairments within their sphere of expertise.) In addition, there ought to be a mechanism to allow the patient to change their PHP, as their primary treatment and rehabilitation needs change.

✚ The OPA recommends that psychologists be considered a PHP of choice for patients with brain injuries and psychological impairments

We also note some contradiction with regard to the discussion of conflict of interest that requires clarification with regard to the PHP model. The current FSCO report states, *"FSCO also believes that designating a health professional who is not delivering services to coordinate rehabilitation would eliminate the potential conflict of interest situation inherent in the existing delivery model. As such, the designated health professional could not be another provider at the facility or clinic where the claimant is receiving treatment."*

However, we note that this differs from the definition provided in previous communication and provide the following clarification, "Conflict of interest", in the provision of medical and rehabilitation services has been described in the past by FSCO specifically as benefit from referral to another person:

The *Guideline Respecting Conflict of Interest in the Provision of Medical and Rehabilitation Services* published by FSCO, August 26, 1997 (See Appendix) states:

Self-Referrals

The conflict of interest provisions indicate that the person who receives a financial benefit would have to profit from services provided by another person. Therefore, if the health professional who prepares the Treatment Plan is the person who will treat the insured person, no conflict of interest exists.

Referrals within a Facility

The conflict of interest provisions are also not intended to extend to co-workers within a facility. If the person completing the Treatment Plan is employed by or is under contract with the same facility that provides the treatment, no conflict of interest exists.

Referrals for Profit

If the person who prepares the Treatment Plan receives a financial benefit for referring the insured person to a treatment facility, a conflict of interest exists. However, no conflict of interest exists if the person who prepares the Treatment Plan is an employee of the same facility that will be carrying out the treatment. If the insured person is referred to a treatment facility by another person who will receive a financial benefit, a conflict of interest exists. However, no conflict of interest exists if the person making the referral is an employee of the same facility.

In accord with this Guideline, and professional practice, it is our understanding that conflict of interest prohibitions are not intended to interfere with the necessary process of the health professional providing assessment and provision of treatment to their patient.

The OPA agrees that addressing conflict of interest and “referrals for profit” is an important issue. However, this should not be confused with the appropriate and necessary role of the health professional assessing and treating their patient. This is fundamental to health care delivery and does not constitute a “conflict of interest”.

In contrast, it is a conflict of interest for the treating PHP to refer their patient to another service or service provider where there is a covert relationship or financial benefit to the PHP. Conflict of interest and financial relationship to the other service or service provider receiving a referral must be declared. In these instances, both the patient and the insurer would need to waive the conflict for the referral to proceed. Kickbacks or fees for referrals are unacceptable, illegal, and already prohibited in the regulations. We support the enforcement of these provisions.

✚ OPA recommends that while there is no conflict of interest in providing assessment and treatment to one's own patient, perceived concerns regarding conflict of interest in referrals should be addressed.

Active involvement in the patient's treatment/rehabilitation assures that the PHP is knowledgeable about the condition and needs of the patient. It also assures the patient of a health care provider/patient relationship and commitment to the best interest of the patient for their rehabilitation. Active involvement in the treatment of the patient avoids the additional cost of another person involved solely in the coordination of the services. Since the services of psychologists are not paid for by OHIP or other public funding mechanisms, assessments and treatments to the patient must be funded through the no-fault system. The psychologist and other non-physician PHP would continue to submit requests for assessments and treatment plans when indicated.

✚ The OPA recommends that the PHP provide direct services as well as referrals to other services and service providers

Any fees for completion of forms and communication with other health providers must be submitted to HCAI. The HCAI database is required for identification of patterns of referrals and costs of these coordinating activities.

✚ The OPA recommends that the PHP be part of electronic submission process i.e. HCAI

Some stakeholders have proposed requiring a "case manager" to make all referrals, including for accident victims who do not have catastrophic impairments. They have suggested that that the case manager would be determined on some basis from a roster and not selected either by the insurer or the accident victim. The OPA finds this option would unnecessarily increase complexity and add costs to the system. In addition, it would interfere with the patient's ability to choose their own treating health professionals and have those professionals direct their care.

We are also aware of some suggestions that the insurer hire an internal health professional to be in the role of managing and directing the patients care, determining appropriate referrals, or require the utilization of preferred providers. The OPA finds these proposals interfere with the accident victim's ability to choose their own treatment providers and the responsibility of those treatment providers to direct patient care.

✚ **The OPA cannot support proposals for “case management” for patients who do not have catastrophic impairments, or utilization of insurer case managers.**

FSCO Recommendation #22: Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to \$25,000. Introduce a \$100,000 optional medical and rehabilitation benefit along with the existing \$1 million optional benefit.

The OPA notes that the FSCO report contains the benefit limit suggested in the IBC submission of \$25,000 as well as the inclusion of Section 24 assessments in this amount. An alternative suggested by the IBC is that patients who had been hospitalized for two consecutive days have access to \$100,000.

The FSCO Report, *“One key objective of Ontario’s no-fault accident benefit system is to meet claimants’ immediate needs following an automobile accident and provide prompt payment of benefits without regard to fault. Without a system of prompt payments, claimants could be left without the ability to pay for ongoing household and living expenses and medical and rehabilitation costs resulting from an accident”*. If a new reduced basic policy limit of \$25,000 is incorporated into the SABS, there will be a yawning gap between \$25,000 for medical and rehabilitation benefits and \$1,025,000 for those who meet a catastrophic impairment definition. In addition, many of those who have a catastrophic impairment will not have timely access to funds for their treatment and rehabilitation as they wait for the determination process.

A characteristic case scenario may assist this analysis: Psychologists assess and treat many crash victims with serious orthopaedic injuries, in response to their psycho-traumatic disorder, coping with persistent pain, onset and development of mood disorder, impact of cognitive impairment, and vocational retraining. Patients require acute services on discharge from hospital, physiotherapy after surgeries, in home assessments for safety and home modifications, psychological treatment for acute trauma and post traumatic stress disorder and mood disorder, functional evaluation of the impact of injuries, vocational evaluation and retraining. Another variation on this case is the patient where persistent pain and sleep disorder and associated mood disturbance predominate so that they cannot return to home and community and family function or pre MVA employment. These patients receive a wide variety of pain management approaches includes manipulative therapies, medications, injections, psychological pain management, and group based pain programs in addition to vocational retraining when recovery allows.

Unless home modifications were involved, many such patients had their needs for treatment met within the \$100,000 cap. With the proposed capping of benefits at \$25,000, most patients with similar scenarios will not have sufficient funds to address their treatment/rehabilitation needs. Present catastrophic impairment definitions exclude most of these accident victims, and

those that are included, will often need to wait at least two years or longer post MVA for the criteria to be applicable when medical and rehabilitation benefit has been exhausted.

Optional benefits will fail to address this need to have ability to pay for ongoing medical and rehabilitation expenses in many instances. While we appreciate that brokers and others will be expected to provide greater public education regarding the optional benefits, many individuals are not in a position to have this option, for example, those who do not drive and therefore do not purchase auto insurance. It is also the case that many will assume that the basic level will be sufficient for their needs since that is all that is being required and not having prior experience with the costs associated with rehabilitation from injury. Similarly the recovery in Tort for those accident victims who sue the at-fault driver will not provide the funds for payment of timely treatment and rehabilitation.

We note that insufficient funding for appropriate and timely treatment and rehabilitation poses a risk of harming the health of the individual accident victim and limiting their ultimate recovery. It also poses a risk of shifting the burden of care and cost to OHIP and other publically funded systems. Accident victims will continue to receive IRBs but will exhaust funds to mitigate their losses. Some will receive continuing attendant care but not have funds for treatment and rehabilitation. The present system where benefits are integrated and support each other would be replaced by a patchwork of incomplete benefits for treatment and rehabilitation.

We note that psychological impairments often arise in response to failure of anticipated physical recovery and restoration of function when the accident victim becomes aware that they will be unable to resume their pre-MVA roles in personal, family and work life. At this point, when they are in need of psychological treatment to address adjustment and anxiety disorders or depression and adaptation to new physical or cognitive limitations, funding for these services will have been exhausted.

 **The OPA strongly recommends retaining the \$100,000 basic benefit level.**

FSCO Recommendation #23: to examine the feasibility of expanding the PAF Guidelines to provide a more extensive continuum of care and to include the treatment and assessment of other soft tissue injuries.

The inclusion of additional injuries may allow more patients to have more streamlined access to acute care, as no insurer prior approval is required for this program. However, care will be required to ensure that with the addition of other injuries, the evidence exists to treat individuals with this wider group of injuries as a homogeneous group. Inclusion and exclusion criteria for both injuries and patient characteristics will need to be determined.

Similarly increasing the continuum of care available in the PAF may make it appropriate for a larger group of patients. However this must be balanced against the cost associated with

increasing the services available within the PAF. Specific exclusion criteria will need to be determined as well as processes for exiting the PAF if it is found not to be appropriate. The process for reasonable and necessary post PAF treatment needs to be clearly defined.

The OPA is aware of the suggestion from the IBC, for a slight expansion in the funding available for patients in the PAF and to include additional funding for examination and treatment by a social worker or psychologist if psychological manifestations are present. While this may sound like a helpful proposal, the funding proposed is \$500. We point out that at the FSCO, PSG rate this would only allow for approximately 3.75 hours for both examination and treatment, which would be insufficient for most individuals presenting with psychological concerns.

Even more concerning is the IBC's proposal to manipulate the PAF into a stream of care with a hard cap of only \$1500 for all post PAF assessments and treatment. It is both scientifically incorrect and clinically unsound to assume it is possible to predict individual outcome and future treatment needs based on initial diagnosis and placement into a treatment stream.

The OPA stresses that it is clinically inappropriate to rely on any further elaboration of the PAF to create a "hard cap" on benefits for those who are initially diagnosed as appropriate for treatment within that program. Similarly the OPA cannot support the IBC's suggestion to preclude access to attendant care, in home and worksite assessments, and to limit ancillary benefits for housekeeping, home maintenance and care-giver support to two weeks to patients who receive their treatment within this program.

✚ While the OPA recommends exploration of further elaboration of the PAF, we stress that it is clinically inappropriate to rely on initial diagnosis and participation in the PAF to limit access other benefits and to post PAF treatment.

FSCO Recommendation #27: increase the maximum income replacement benefit to \$500 per week.

The OPA is aware of the additional stress caused to accident victims and their families if they are unable to meet their financial obligations due to their accident injuries. The OPA cannot support the suggestion of some stakeholders to make income replacement an optional benefit. Income protection must continue to be part of the basic coverage provided to all citizens. If auto insurance did not provide this coverage there would be increased harm to the most vulnerable citizens as well as shift of burden to public welfare systems.

✚ OPA supports the increase in the income replacement benefit

FSCO Recommendation #28: conduct annual review of reimbursement rate for travel in a personal vehicle.

✚ OPA supports annual review of the reimbursement rate for travel as well as reconsideration of the exclusion of the first 50 kilometres per round trip as this may pose a financial burden on those who are living with reduced income due to their accident injuries.

FSCO recommendation #29: to make housekeeping and home maintenance expenses and caregiver benefits optional.

These benefits are often essential to allow the accident victim to participate in their rehabilitation and to maintain a viable family life for their dependent children in the first few weeks and months after an accident. This may be disproportionately unfair to elderly and women who are not employed outside the home. There are a small group of accident victims with brain and orthopaedic injuries who require these services for prolonged periods of time.

✚ OPA recommends that housekeeping, home maintenance and care giving remain part of the basic benefits package.

FSCO Recommendation #31: The government should consider reducing the deductibles to \$20,000 and \$10,000, eliminating the deductibles for fatal claims, and revoking the definition of serious and permanent impairment set out in Regulation 461/96.

✚ The OPA supports the removal of the definition of serious and permanent impairment that added unnecessary complexity

FSCO Recommendation #32: amend the SABS to provide for an appropriate cap on the cost of accounting reports to substantiate a claim for weekly benefits

The OPA agrees that the present cap of \$1500 is inadequate for the cost of these expert reports. We note that the FSCO report suggest that a payment option for these reports is the rebuttal fee, however, the report also recommends removing the rebuttal fees and notes that these fees are capped at \$450 and \$900 and often inadequate for these expert reports.

✚ The OPA recommends amending the cap on expert reports.

FSCO Recommendation #35: insurance claims departments need to better focus on the needs of claimants with serious injuries.

The OPA is prepared to be a resource to insurance companies to assist in the training of adjusters regarding the needs of claimants with serious impairments due to psychological disorders and brain injuries.

✚ The OPA recommends specialized training for adjusters who work with accident victims with serious injuries and would welcome an opportunity to participate in educational programs.

FSCO Recommendation #36: consumers, health care providers and insurers should work together to improve consumers' awareness and expectations around treatment and outcomes.

✚ The OPA would welcome the opportunity to work together with consumers and insurers to develop educational endeavours and deliver programs regarding treatment and outcomes.

Conclusion

In the body of this response we have provided detailed comment on recommendations that are particularly relevant for patients with psychological impairments, including brain injuries. We have raised the OPA's concerns that some of these recommendations will cause harm to

seriously injured accident victims. Our greatest concern is that seriously injured patients will exhaust the FSCO recommended \$25,000 benefit limit quickly, and be offloaded to the OHIP system, which does not provide funds for ongoing rehabilitation in the community. While these recommendations may have been well intended, some of them do not meet the goal of protecting injured consumers.

Please feel free to contact us if we can provide any clarification.

We also hope to have the opportunity to participate in the recommended processes to address: the expansion of the Pre Approved Framework, review of the catastrophic impairment criteria, development of standards and qualifications for third party examiners, review of specific regulations to implement the recommendations, and any other areas where our particular expertise and health professional perspective may help to facilitate sound policy and implementation mechanisms.

Thank you for the opportunity to present these responses to FSCO's recommendations for auto insurance reform.

The Ontario Psychological Association
Auto Insurance Task Force

A handwritten signature in black ink, appearing to read 'Ron Kaplan', with a stylized flourish at the end.

Ron Kaplan, C. Psych, Ph.D.

Appendix

FSCO Psychology, Assessment and Treatment Guidelines - 2001

PART I: PSYCHOLOGY ASSESSMENT GUIDELINE

The cost of assessments is based on the actual time spent completing the assessment. In applicable patient situations¹, the maximum cost will not be more than \$2,700 for a general psychological assessment or \$4,500 when a combination including neuropsychological, psycho-educational, or psycho-vocational assessments are included, but the amount of time spent on each intervention may vary from case to case. Psychological assessments reasonably include the following diagnostic interventions: Clinical Diagnostic Interview(s), Clinical Diagnostic Interview with collateral source, Psychological Testing, Review of External File Materials, Consultation, Documentation, and Feedback Interview. The amount of time spent on each diagnostic intervention will vary between assessments. This guide indicates the cost of the basic intervention of each type, plus "Extent Attributes" which are additional work required, depending on the individual factors of the case. Use of extent attributes increase the cost of that intervention. It is the responsibility of the psychologist who is completing the assessment to determine which interventions and extent attributes are reasonable and necessary. When required, cost of completion of the OCF 18 is \$75, and disbursements and travel time are additional.

Diagnostic Intervention & CCI	Basic ² Hours	Cost ³	Plus Extent Attributes
Clinical Diagnostic Interview(s) 2.AZ.02	2.5	\$450	Need for additional patient interviews. Increase time as per additional interview(s) e.g. further interview(s) required due to intellectual limitations/slowness, and/or to clarify complex history, causation, clinical presentation or multiple impairments.
Clinical Diagnostic interview with collateral source 2.AZ.02			Need for collateral interviews. Increase time as per additional interview(s) e.g. with family, teacher, employer
Psychological Testing 2.AZ.08 (First Level: Clinical Health / Rehabilitation): Test administration, recording and scoring. May include: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, trauma, family/ social relationship functioning, cognitive functioning, rehabilitation status	3	\$540	Requirement for additional more extended specific test procedures to address outstanding diagnostic and impairment issues: Additional testing to elaborate findings from First Level: Clinical Health/ Rehabilitation testing- increase hours by 1-6 e.g. self- report inventories are inappropriate/insufficient; further testing re: cognitive dysfunction, psychological dysfunction, behavioural disorder, competency evaluation. Additional Specific Assessments: (see Psycho-educational / Psycho-vocational assessment and Neuropsychological assessment) Neuropsychological – increase hours by 3 – 12; Psycho-educational – increase hours by 3 – 12; Psycho-vocational – increase hours by 4 – 12
Review of External File Material 7.SJ.30ZZ including medical chart, IMEs, DACs, school and work records	1	\$180	File contents beyond 50 pages: Increase by .25 hour for each additional 25 pages of documentation
Consultation 7.SF.12 Documentation 7.SJ.30ZZ Includes: analysis of all data; formulation of a diagnosis; plan for treatment; and preparation of an assessment report	4	\$720	Consultation with health professionals and the insurer required: Increase hours by 0.25 per consultation Complex situations which require more extensive data analysis and documentation. Actual time reasonably spent
Feedback Interview 2.AZ.02 Review of assessment findings, treatment planning and obtaining consent for treatment and communication	1.5	\$270	Complex situations which require additional diagnostic feedback interviews: increase time as per additional interview(s) e.g. patients with intellectual limitations/slowness or with severe and multiple psychological impairments may require additional feedback interviews

1. This Guideline does not apply to a patient who is a child, has a pre-existing severe psychological disorder, has a significant communication disorder or limited English (when reasonably available, patients should be assessed by a psychologist speaking the patient's native language). 2 The work of ancillary personnel such as psychometrists will be separately identified on any invoice with the nature of the service provided and the hourly rate charged. When ancillary personnel are utilized to administer part of the assessment, the total hours may be greater than those illustrated above, but the combined cost of their time, plus the hours of the supervising psychologist will not exceed the maximum cost of the assessment indicated above. 3. The maximum costs in this guideline are calculated on the basis of the maximum hourly rate of \$180 in effect until December 31, 2001 and are thereafter adjusted by changes in the hourly rate.

Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims – January 11, 2005

Assessment Activities	
Assessment Intervention and CCI Code	Hours
Table #1 Guideline for General Clinical/Health/ Rehabilitation Psychological Assessment	
Indicators for Assessment: A General Clinical/Health/Rehabilitation Psychological Assessment is reasonably required when the intake screen suggests that: <ul style="list-style-type: none"> • A claim has been made for the MVA to which the impairments are attributed; <u>and</u> • The patient consents to the proposed assessment and necessary communications with their treating health professionals and their insurer; <u>and</u> • The following are suspected/ reported associated with an MVA: <ul style="list-style-type: none"> ○ Psychological impairment <u>or</u> ○ Symptoms of psychological distress or role impairment; <u>or</u> ○ Psychological factors affecting the patient’s response to other treatments for MVA-related impairments, <u>or</u> ○ Presence of “Yellow Flags” as defined by the New Zealand Guide to Red and Yellow Flags; <u>or</u> ○ Interference with usual home, school, or work life due to psychological impairments. 	
Clinical Interview(s) with Patient and Collateral Sources (2.AZ.02) Time required within the range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g., due to intellectual limitations, language impairments/ disabilities, need to clarify a complex history, issues of causation, unusual clinical presentation, or multiple impairments.	2.5 - 6
General Clinical/ Health/ Rehabilitation Testing (2.AZ.08) Includes test administration, scoring and interpretation. Assessment may include testing the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general intellectual/cognitive functioning, rehabilitation status and validity measures. Time required within range is dependent upon need for more depth/ breadth of testing.	1 - 5
Disbursements (G.XX.99) Appropriate disbursements may include cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Review of External File Material (7.SJ.13) Includes review of medical chart, IMEs, DAC reports, school and work records. Time required within the range is dependent upon the complexity and length of the file.	1 - 4
Consultation with Health Professionals, the Insurer, or Others as Required (7.SF.12) Time required within the range is dependent upon the need for additional consultations and/or information gathering from other parties to clarify assessment issues.	.5 - 2
Documentation (7.SJ.30) Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within the range for complex situations that require more extensive data analysis and documentation.	4 - 6
Feedback Interview (2.AZ.02) Includes review of assessment findings, treatment planning, and obtaining consent for treatment and communication. Time required within the range increases with need for longer or additional interview(s), e.g., patients with intellectual limitations, language impairments/disabilities, or with serious or multiple psychological impairments.	1 - 2
Total Assessment Hours	10 - 25*
<small>* Note: these times do not include the fees for completion of required OCF forms or for disbursements such as obtaining records and test data, or consumable test materials and scoring services. Patients with exceptional characteristics may reasonably require additional time and costs beyond the ranges shown. Such exceptions include: geriatric adults, children, adolescents and any patients or other interviewees (e.g. parents/ caregivers) who have severe psychological disorders, moderate to severe cognitive impairments, significant communication disorders, or language limitations requiring use of an interpreter (when reasonably available, services should be provided in the person’s native language.)</small>	

Table #2 Guideline for Neuropsychological Assessment	
Indicators for Neuropsychological Assessment: When neuropsychological concerns including reports of cognitive impairments/ deficits, post-concussion type symptoms, and history suggestive of concussion/ brain injury are noted, neuropsychological assessment is reasonably required. Neuropsychological assessments are diagnostic, descriptive, and prescriptive and are not limited in relevance to patients with evidence of structural brain damage, but are also necessary to document impairments in patients with possible/probable general clinical psychological disorders, and neuropsychological and neurobehavioural disorders. Neuropsychological assessment provides objective documentation of cognitive and motor complaints and is useful for planning treatment and rehabilitation, educational and vocational integration.	
Assessment Activities	
Assessment Intervention and CCI Code	Hours
Clinical Interview(s) with Patient and Collateral Sources (2.AZ.02) Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/ disabilities, need to clarify complex history, causation, unusual clinical presentation, or multiple impairments.	2.5 - 6
Neuropsychological Testing (2.AZ.08) Includes test administration, scoring and interpretation. Assessment may include testing the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status and administration of validity measures. In addition, Neuropsychological Assessments may include sensory abilities; motor skills; psychomotor speed; attention/concentration; language; visuo-spatial/ constructional abilities; intellectual abilities; memory and learning; executive functioning; judgment; self awareness; initiation; and self-control. Time required within range is dependent upon need for more depth/ breadth of testing	8 - 12
Disbursements (G.XX.99) Appropriate disbursements may include cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Review of External File Material (7.SJ.13) Includes review of medical chart, IMEs, DAC reports, school and work records. Time required within range is dependent upon the complexity and length of the file.	3 - 8
Consultation with Health Professionals, the Insurer, and Others Required (7.SF.12) Time required within range is dependent upon need for additional consultations and/or information gathering.	.5 - 2
Documentation (7.SJ.30) Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	5 - 8
Feedback Interview (2.AZ.02) Includes review of assessment findings, treatment planning, and obtaining consent for treatment and communication. Time required within range increases with need for longer or additional interview(s), e.g., patients with intellectual limitations, language impairments/ disabilities or with serious and multiple psychological impairments.	1 - 3
Total Assessment Hours	20 - 39*
* Note that these times do not include the fees for completion of required OCF forms or for disbursements such as obtaining records and test data, or consumable test materials and scoring services. Patients with exceptional characteristics may reasonably require additional time and costs beyond the ranges shown. Such exceptions include: geriatric adults, children, adolescents, and any patients who have severe psychological disorders, significant communication disorders, or language limitations requiring use of an interpreter (when reasonably available, services should be provided in the person's native language.)	

Table #3 Guideline for Psychovocational Assessment	
Indicators for Psychovocational Assessment: When vocational issues are anticipated, for example, difficulty returning to or maintaining level of performance in former employment, need to identify suitable alternative employment type or vocational retraining needs, then psychovocational assessment is reasonably required.	
Assessment Activities	
Assessment Intervention and CCI Code	Hours
Clinical Interview(s) with Patient and Collateral Sources (e.g., employer) (2.AZ.02) Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/disabilities need to clarify complex history, causation, unusual clinical presentation or multiple impairments.	2.5 - 6
Psychovocational Testing (2.AZ.08) Includes test administration, scoring and interpretation. Assessment may include testing the following domains: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/ social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status and administration of validity measures. In addition, Psychovocational Assessments may include testing of intellectual abilities; academic aptitude (reading, writing, numerical); communication/language abilities (expressive, receptive); organizational and planning skills; abstract reasoning; distractibility; vocational aptitude; vocational interests; task skills analysis; transferable skills; endurance; persistence; adaptation and flexibility; motivation; achievement need; and learning ability. Labor market assessment may be required. Time required within range is dependent upon need for more depth/ breadth of testing	8 - 12
Disbursements (G.XX.99) Appropriate disbursements may include cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Review of External File Material (7.SJ.13) Includes review of medical chart, IMEs, DAC reports, school and work records and Labour Market documentation. Time required within range is dependent upon the complexity and length of the file.	3 - 8
Consultation with Health Professionals, the Insurer, and Others Required (7.SF.12) Time required within range is dependent upon need for additional consultations.	.5 - 2
Documentation (7.SJ.30) Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	5 - 8
Feedback Interview (2.AZ.02) Includes review of assessment findings, treatment planning, and obtaining consent for treatment and communication. Time required within range increases with need for longer or additional interview(s), e.g., patients with intellectual limitations, language impairments/disabilities, or with serious and multiple psychological impairments.	1 - 3
Total Assessment Hours	20 - 39*
* Note that these times do not include the fees for completion of required OCF forms or for disbursements such as obtaining records and test data, or consumable test materials and scoring services. Patients with exceptional characteristics may reasonably require additional time and costs beyond the ranges shown. Such exceptions include: patients or other interviewees (e.g. parents/ caregivers) who have severe psychological disorders, moderate to severe cognitive impairments, significant communication disorders, or language limitations requiring use of an interpreter (when reasonably available, services should be provided in the person's native language).	

Table #4 Guideline for Psychoeducational Assessment	
Indicators for Psychoeducational Assessment: When educational concerns are anticipated, for example, difficulty returning to or maintaining level of performance and progress in former educational program, or need to identify suitable alternative modifications or supports, then psychoeducational assessment is reasonably required.	
Assessment Activities	
Assessment Intervention and CCI Code	Hours
Clinical Interview(s) with Patient and Collateral Sources (e.g., parent, teacher) (2.AZ.02) Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/disabilities, need to clarify complex history, causation, unusual clinical presentation or multiple impairments.	2.5 - 6
Psychoeducational Testing (2.AZ.08) Includes test administration, scoring and interpretation. Assessment may include testing the following domains: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/ social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status and administration of validity measures. In addition, psychoeducational assessments may include testing of intellectual abilities; academic skills and underlying processes (reading, writing, numerical); communication/language abilities (expressive, receptive); organizational and planning skills; abstract reasoning; distractibility; vocational aptitude; vocational interests; task skills analysis; transferable skills; endurance; persistence; adaptation and flexibility; motivation; achievement need; and learning ability. Time required within range is dependent upon need for more depth/ breadth of testing	8 - 12
Disbursements (G.XX.99) Appropriate disbursements may include cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Review of External File Material (7.SJ.13) Includes review of medical chart, IMEs, DAC reports, school records. Time required within range is dependent upon the complexity and length of the file.	3 - 8
Consultation with Health Professionals, the Insurer, and Others Required (7.SF.12) Time required within range is dependent upon need for additional consultations.	.5 - 2
Documentation (7.SJ.30.ZZ) Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	5 - 8
Feedback Interview (2.AZ.02) Includes review of assessment findings, treatment planning, and obtaining consent for treatment and communication. Time required within range increases with need for longer or additional interview(s), e.g., patients with intellectual limitations, impairments/disabilities, or with serious or multiple psychological impairments.	1 - 3
Total Assessment Hours	20 - 39*
* Note that these times do not include the fees for completion of required OCF forms or for disbursements such as obtaining records and test data, or consumable test materials and scoring services. Patients with exceptional characteristics may reasonably require additional time and costs beyond the ranges shown. Such exceptions include: any patients or other interviewees (e.g. parents/ caregivers) who have severe psychological disorders, moderate to severe cognitive impairments, significant communication disorders, or language limitations requiring use of an interpreter (when reasonably available, services should be provided in the person's native language).	

FSCO conflict of interest document, 1997



**Ontario
Insurance
Commission**

**Commission des
assurances de
l'Ontario**

August 26, 1997

**Guideline Respecting Conflict of
Interest in the Provision of
Medical and Rehabilitation Services**

Commissioner's Guideline No. 1/97

Guideline Respecting Conflict of Interest in the Provision of Medical and Rehabilitation Services

[This Guideline is issued pursuant to section 268.3 of the *Insurance Act*, R.S.O. 1990, c.l.8, as amended.]

The Treatment Plan

The *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996* (SABS) sets out a new procedure for insured persons to follow when applying for medical and rehabilitation benefits.

The insured person must submit a Treatment Plan completed by a member of a health profession before incurring expenses for medical or rehabilitation services. For the purposes of the SABS, the Treatment Plan form is the application form for medical and rehabilitation benefits. The Commissioner has approved OCF-18/59 as the Treatment Plan form to be used under the SABS.

When an insured person applies for medical and rehabilitation benefits, the insurer will review the Treatment Plan and decide what goods and services it is prepared to pay for. However, an insurer may waive the requirement for a Treatment Plan where the insurer has agreed to pay for the goods or services.

In addition, an insurer is required to pay for chiropractic or physiotherapy treatment within the first six weeks following the accident, pending the outcome of any dispute over such services. The insured person can attend up to 15 treatments, during the initial six week period, provided that the insured person has submitted a Treatment Plan to the insurer before commencing treatment.

Obligation to Disclose Conflicts of Interest

There are obligations in respect to conflicts of interest imposed on three different groups: health professionals; lawyers, or other persons representing claimants; and insurers.

The obligations with respect to conflicts of interest for health professionals arise in the preparation and signing of the Treatment Plan for the claimant. The obligations are as follows:

- The health professional must disclose any conflict of interest he or she may have in relation to the treatment plan.

- In cases where another person has referred the insured to the persons who will be providing the goods and services under the plan, the health professional must make reasonable efforts to determine whether the person who made the referral has a conflict of interest.
- If the other person who referred the insured person to the treating facility has a conflict of interest in relation to the treatment plan, the health professional must disclose the conflict of interest in the treatment plan.

The OCF-18/59, the form to be used in the preparation of a treatment plan, includes a disclosure statement to be signed by the health professional; this satisfies the requirements.

The obligations of a lawyer or other representative of the claimant is to disclose any conflict of interest to the insurer at the time the application for benefits is submitted.

The insurer is required to disclose any conflict of interest to the claimant within 14 days of receiving the application, unless it has already rejected the application because of a conflict of interest disclosed by the health professional or the claimant's lawyer or other representative.

Conflict of Interest Defined

Section 38(24) of the SABS defines "conflict of interest":

- (a) *A person has a conflict of interest relating to a treatment plan if,*
- (i) *the person or a member of the person's family may receive a financial benefit, directly or indirectly, as a result of the provision, by a member of the person's family or another person, of goods or services contemplated by the treatment plan, and*
 - (ii) *the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services under which goods or services of that kind are provided; and*
- (b) *An insurer has a conflict of interest relating to goods or services to which an insured person is referred by the insurer if the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of the goods or services.*

Member of a Person's Family Defined

Section 38(25) of the SABS defines "member of a person's family":

"member of the person's family" means, in the case of a person who is not a corporation, any other person connected with the person by blood relationship, marriage or adoption, and

- (a) *persons are connected by blood relationship if one is the child or other descendent of the other or one is the brother or sister of the other,*
- (b) *persons are connected by marriage if one is the spouse of the other or of a person who is connected by blood relationship to the other, and*
- (c) *persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child of a person who is connected by blood relationship (otherwise than as a brother or sister) to the other.*

Commentary

Purpose of Disclosure

The purpose of this provision is to identify situations where referrals for profit are likely to exist and where a party is in a position to unduly influence the course of treatment to their own pecuniary advantage.

Where a conflict of interest exists, the possibility arises that the interests of the insured person might not always be paramount. Therefore, where a conflict of interest does exist, the party having the conflict is required to disclose it. Some typical situations that arise are set out below as guidance:

Self-Referrals

- The conflict of interest provisions indicate that the person who receives a financial benefit would have to profit from services provided by another person. Therefore, if the health professional who prepares the Treatment Plan is the person who will treat the insured person, no conflict of interest exists.

Referrals within a Facility

- The conflict of interest provisions are also not intended to extend to co-workers within a facility. If the person completing the Treatment Plan is employed by or is under contract with the same facility that provides the treatment, no conflict of interest exists.

Referrals for Profit

- If the person who prepares the Treatment Plan receives a financial benefit for referring the insured person to a treatment facility, a conflict of interest exists. However, no conflict of interest exists if

the person who prepares the Treatment Plan is an employee of the same facility that will be carrying out the treatment.

- If the insured person is referred to a treatment facility by another person who will receive a financial benefit, a conflict of interest exists. However, no conflict of interest exists if the person making the referral is an employee of the same facility.

Financial Benefit

The regulation provides that a conflict of interest exists if the health professional, lawyer or representative of the insured, or a member of their family, or the insurance company receives a financial benefit, either directly or indirectly, as a result of a referral.

A financial benefit can consist of any thing of value. For the purposes of this regulation, the following types of arrangements would result in a financial benefit being received:

- any benefit received by the person for the referral in the form of a referral fee, commission, rebate, or gift;
- the sharing of profits;
- the expectation of cross referral;
- obtaining or providing goods or services at prices that are substantially higher or lower than the fair market value;
- an agreement between an insurance company and a provider to limit the quantity of services to be provided to insureds who are referred to the provider by the company.

The above examples are illustrative and are not an exhaustive list of the types of arrangements that could result in a financial benefit being received by a health provider, the insured person's lawyer or representative, or the insurance company.

Disclosure by a Health Professional

The regulation places the onus on the health professional completing the Treatment Plan form to make inquiries and disclose any conflicts of interest on the form. The regulation does not require the health professional to provide any other statement respecting conflicts of interest. In particular, the health

professional is not required to provide an insurance company with documented proof that no conflict of interest exists.

Disclosure by the Insurance Company When the Treatment Plan is Waived.

If the insurance company waives the requirement for a Treatment Plan, the company has an obligation to notify the insured in writing of any conflict of interest that the company has with respect to the goods or services provided to the insured.

When a Conflict of Interest is Disclosed

If a conflict of interest is disclosed by the health professional who prepared the Treatment Plan, or by the insured person's lawyer or representative, the insurance company may refuse the Treatment Plan, provided that it notifies the insured person within 14 days of receiving the plan. In this case, the insured person would have to submit a new Treatment Plan that recommends providers who did not have a conflict of interest.

The conflict of interest provisions are not intended to prohibit treatment when a conflict exists but rather require disclosure of such situations. It is intended to eliminate the ability of one of the parties to influence the course of treatment for their pecuniary advantage. Therefore, the insurance company may approve a Treatment Plan despite the existence of a conflict and should exercise discretion before denying plans based on a conflict of interest.

When a Conflict of Interest is Not Disclosed, but is Discovered After the Commencement of Treatment

If an insurance company discovers that a conflict of interest exists with respect to goods or services provided under a Treatment Plan, the company may give the insured person notice that the insured has 14 days to amend the Treatment Plan to remove the conflict of interest. This would mean that the insured person would have to be referred to another health provider who did not have a conflict of interest. The insured would receive goods or services from the new health provider.