

# Ontario Psychological Association



## **Joint OPA-CAPDA Feedback**

### **Fair Benefits Fairly Delivered: A Review of the Auto Insurance System in Ontario**

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## JOINT OPA-CAPDA FEEDBACK

### “FAIR BENEFITS FAIRLY DELIVERED: A REVIEW OF THE AUTO INSURANCE SYSTEM IN ONTARIO”

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This document was jointly prepared by the following two professional Associations whose members have extensive experience in providing comprehensive assessments and evidenced-based care for victims of car collisions – as well as, the auto insurance system as it has evolved over the past several years. They are as follows:

#### THE ONTARIO PSYCHOLOGICAL ASSOCIATION (OPA)

The Ontario Psychological Association acts as the voice for the profession of psychology in Ontario. The goals of the Association set out in its Articles of Incorporation goals include enhancing the psychological health of Ontarians, and bringing research acquired psychological knowledge to bear on the provision of mental health services in order to ensure their quality and effectiveness. The OPA works to establish cooperative relationships with other healthcare providers, organizations, and the government. ([www.psych.on.ca](http://www.psych.on.ca))

#### CANADIAN ACADEMY OF PSYCHOLOGISTS IN DISABILITY ASSESSMENT (CAPDA)

The Canadian Academy of Psychologists in Disability Assessment (CAPDA) is an organization of senior psychologists who practice primarily in the areas of psychological or neuropsychological assessment of disability and impairment. There are stringent requirements for membership, and all members are bound by comprehensive standards which guide their practice and outline their obligations to the individual assessed and to the referral source. It is the mission of CAPDA to share information, develop standards of practice and conduct; educate, and advocate on matters related to third party requested assessments and other assessments and on matters of rehabilitation and disability. CAPDA is a national organization and is invested in developing similar guidelines relevant to psychologists across Canada. ([www.capda.ca](http://www.capda.ca))

## INTRODUCTION

In this joint submission, the Ontario Psychological Association (OPA) and Canadian Academy of Psychological Disability Assessors (CAPDA) will address important issues raised in the report of the review of the auto insurance system (Report): trustworthiness, disputes, and costs in the auto insurance system. We agree with the Report's objective to increase access to care for injured persons and to reduce the percentage of funds spent on costs that do not provide services to foster recovery such as Insurer Examinations (IEs). We will focus on providing strategic solutions in several areas:

- Increasing trust in health professionals who provide care and improving access to effective treatment to restore function;
- Improving quality and trust in Insurer Examinations (IEs), reducing disputes and “competing opinion examinations”;
- Catastrophic Impairment (CAT);
- Issues regarding legal representation and legal fees and Tort; and,
- The Role of the Regulator.

The thirty-nine (39) interrelated solutions described in the next sections of this document can be readily implemented. (See Appendix 2 for the list of solutions.) They build on existing mechanisms, incorporate the government's recent and significant changes to auto insurance, as well as some of the constructive recommendations provided in the Report.

We note that the government has recently brought in major changes in the auto insurance system including: reducing the amount and duration of benefits; and introducing a new and streamlined service for more cost effective and timely dispute resolution. Many of these changes are only now being implemented. The system has not yet had the time to collect and analysis the benefits of these promising changes. We offer solutions that will build on and further utilize these initiatives.

We agree with the Report that the current system can be more effective and efficient and we describe strategic solutions to achieve these goals. The solutions we describe are interrelated and reinforce each other. In presenting our solutions, we also address the core issues of trustworthiness, disputes, and costs.

Although the solutions in our submission do not appear dramatic, they will result in **significantly** increased trustworthiness, reduced disputes, and reduced costs. In addition, our solutions also have less risk of creating significant disruption or unintended negative consequences compared to some of the major system changes recommended in the Report. We are seriously concerned about the unintended negative consequences for injured individuals that would result from implementing some of the Report's recommendations, for example, the recommendations associated with the requirements for pre-emptive, binding IECs. In addition to interfering with the healthy professional/patient relationship which is the basis of care for the injured individual, the IEC model would reduce trust, increase costs, and shift the responsibility for care and the associated costs to the Ministry of Health and Long-Term Care (MOHLTC) and other publicly funded systems, such as the Ministry of Community and Social Services (MCSS), as well as other insurer programs, such as health benefits.

Although not addressed in the Report, we would also like to see greater emphasis on accident prevention and harm reduction. Initiatives to reduce distracted and impaired driving are critical at this time. Further incentives are needed to increase utilization of vehicles with feedback technologies that encourage safe driving and other assisted technologies that reduce risk of accidents.

Our comments and proposed solutions are consistent with the *Patients First* philosophy of health care to improve the efficiency of care, restoration of function and ultimate health outcomes. Our solutions provide alternative mechanisms which improve fairness to injured persons and premium payers and are consistent with the philosophy of the government to increase fairness for all Ontarians, especially the most vulnerable.

Our key solutions include the following:

- Require use of a standard format for reporting treatment outcome;
- Reinforce the “Patient’s First” approach to care;
- Allow **all** insured persons access to initial funding funding for care without being subject to insurer denial or IE (dollar value and time period to be determined). Eliminate insurer denials and IEs for **all** care applications under a pre-determined dollar threshold and initial time period;
- Introduce explicit criteria for routine insurer approval of funding for treatment planning assessments without requiring an IE for injured individuals with non MIG/Non CTI injuries;
- Require health professionals to confirm that treatment plans are consistent with standards of practice and treatment guidelines;
- Retain cash settlements of Accident Benefits;
- Create an enforcement mechanism that incorporates the LAT requirement for experts to provide opinion evidence that is “fair, objective, and non-partisan”;
- The insurer shall offer the insured person five IE examiners/facilities from which the insured person will select one;
- Retain the model that allows IEs be delivered by: private community based facilities; large IE companies; or by hospital based facilities (i.e., Do not require IEs to be hospital based or centralized);
- Allow an IE only when the insurer has a reason to question an application from the insured persons’ health professional(s) Do not make IEs “pre-emptive”;
- Provide opportunity for the insured person to obtain opinion from their health professional(s) if they disagree with an IE. Do not make IEs “binding”;
- Utilize peer review and consultation between health professional peers to address differences of opinion to improve quality and efficiency of IEs regarding care; and,
- Faciliate a more collaborative process to address differences between the treating health professional and the IE examiner prior to proceeding to dispute regarding care.

In the following section we will provide further description of and explanation for these solutions and additional ones.

In this submission it is not possible to fully outline all of the details of the proposed solutions. Some also require further development and stakeholder input for implementation. We would very much appreciate further opportunity to participate in these processes.

## Solutions

### Section 1: To increase trust in health professionals providing care and to improve access to effective treatment to restore function.

#### **SOLUTION # 1: *Maintain the current, recently reduced, levels of no-fault benefits***

Significant savings will be achieved in accident benefit costs due to the major reductions to no-fault benefits introduced in 2016. These major reductions include:

- Reducing the level of medical rehabilitation and attendant care benefits for those with non-minor injuries from \$72,000 to \$65,000;
- Reducing the period of coverage from 10 to 5 years;
- Reducing non-earner benefits from lifetime to 2 years;
- Reducing benefits for those with CAT impairments by 50% (reducing the benefits from a total of \$2,000,000 to a total of \$1,000,000); and,
- Creating more restrictive CAT definitions that will greatly reduce the number of CAT determinations for individuals with brain injuries, mental disorders, and multiple serious injuries and impairments.

The cost saving of these changes is obvious both in terms of reduced benefit levels and lower administrative and transaction costs due to significantly shorter claim durations.

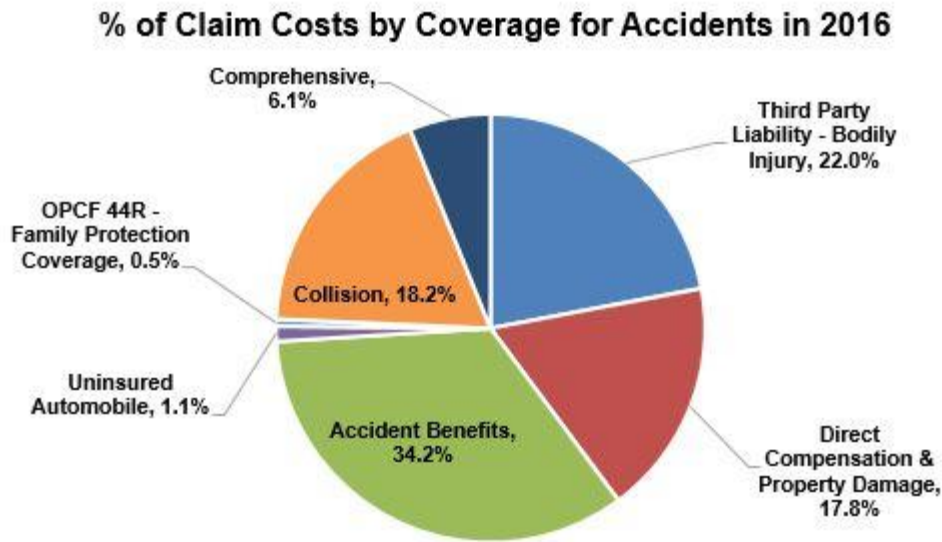
We are concerned that severely impaired individuals who would meet the CAT definition will run out of standard level benefits to fund treatment prior to the timeframe for a CAT determination, leaving them without necessary treatment. There are also reports of injured individuals with very serious but non-CAT injuries without a Tort claim for whom the reduced level of benefits is insufficient.

Future consideration and further evaluation is required to determine if the recovery of some groups of injured individuals is excessively harmed by these recent reductions and/or if there are unacceptable offsets to the Ministry of Health and Long-Term Care (MOHLTC) and other publicly funded systems, such as the Ministry of Community and Social Services (MCSS) and insurer payments for health benefits. If so, benefit levels should be adjusted. In addition, although auto insurance is often described as a “closed system” where-in premiums must cover the benefits paid, it is also true that, when the benefits are insufficient, there is off-set to other public systems such as health and welfare and other insurer payment systems, such as health benefits. Further study regarding these social and economic costs would help to determine if there are unacceptable transfers of costs from auto insurance to the public and other private sector purses.

Certainly, further reductions of benefits would only compound these potential harms to patients and additional cost burdens created by inadequately funded treatment that we are highlighting.

#### **SOLUTION # 2: *Focus further cost saving efforts on non- Accident Benefit costs***

As described above, there have been significant reductions in accident benefits. At this time, the majority of injured individuals are limited to a maximum of \$3500 in medical and rehabilitation benefits. In addition, for those who are potentially eligible to receive higher levels of medical and rehabilitation funding and other benefits, there are significant cost controls in place. Further reductions and controls will undermine the ability of no-fault benefits to provide funding for treatment and other benefits to restore the function of the injured person. The following illustration, “Auto Insurance Rates for the Second Quarter of 2017” from the Financial Services Commission of Ontario (FSCO) website shows the proportion of claims costs that are attributed to accident benefits:



2016 GISA Automobile Statistical Plan AUTO1005  
Private Passenger excluding Farmers Actual Loss Ratio Exhibit

*NOTE: The above numbers may not add up to 100 per cent due to rounding.*

**Accessible Description of Graph 1:**

*Accident Benefits 34.2 per cent, Third Party Liability - Bodily Injury 22.0 per cent, Direct Compensation and Property Damage 17.8 per cent, Collision 18.2 per cent, Comprehensive 6.1 per cent, Uninsured Automobile 1.1 per cent, OPCF 44R Family Protection Coverage 0.5 per cent.*

The above graph is based on GISA data includes **all** incurred claims costs, including those paid by the insurer as a part of a case settlement. Accident Benefits costs also include the costs of IEs, and other benefits (income replacement and attendant care) paid on behalf of the injured person (This differs from HCAI data which includes only costs of services that are invoiced and paid through the HCAI system). This graph illustrates that the **total** costs of Accident Benefits comprise only 34.2% of claims costs. This graph is based on the 2016 data and reflects the costs of Accident Benefits without the significant cost reductions that will ensue when recent changes are fully implemented.

There are other contributors to the cost of auto insurance that should be investigated and addressed to achieve cost savings without further reducing the benefits available to injured individuals. We are aware of

reports of excessive charges for towing, storage and auto repair. Other cost drivers, such as broker commissions and “bonuses”, should be explored. In addition, costs under the control of the insurance companies should be considered such as:

- Decisions regarding compensation;
- Management efficiencies;
- Level of profit and return on equity; and,
- Other opportunities under the control of the insurer community.

### ***SOLUTION # 3: Include more complete data regarding costs of care and other accident benefits in the Health Claims for Auto Insurance (HCAI) Database.***

Social policy decisions are best made when informed by up-to-date, accurate and relevant information. While there has been attention paid to methods to reduce the costs of the auto insurance system, this discussion could be vastly improved if there was more shared understanding of the cost drivers. The use of anecdotal constructs that distort our abilities to measure the results of change processes needs to be replaced by a just-in-time data collection and analysis that is readily available to consumers, providers, insurers and decision-makers.

The current HCAI database and standard data reports provide a first step in this process. Most treatment plans and invoices for treatment services must be submitted through the HCAI system. Similarly, insurers must enter their decisions on treatment applications and invoices for these services on the system.

The development of the HCAI database has been a project that has involved FSCO and multiple stakeholders. It has required significant investment of time and capital to establish this resource. Minor changes to the requirements for data entry would build on the existing resource and make the HCAI data more useful to better identify ways to improve the system and achieve cost savings. This additional information would include, but not be limited to, the following data entry requirements, regarding costs and other factors:

- **All** treatment costs;
- **All** Attendant care costs;
- The costs of income replacement;
- The settlement amounts, ideally attributed to treatment, attendant care, income replacement, etc.;
- Minor injury and/or CTI status, Catastrophic Impairment (CAT) status; and
- IE costs broken down by type, and outcome

Without a more complete database, policy decisions are being made that are not fully informed. While the current HCAI data provides some understanding of current costs, more complete data would be extremely useful for determining how funds are being spent and where real cost savings can be accomplished without causing undesired negative consequences such as higher disability or settlement costs.

### ***SOLUTION # 4: Create an impartial body to develop materials and processes to better educate consumers, insurers, and health professionals***

The Report states the following:

*“Consumer education in the field of auto insurance is a key component of a well-functioning system. In conjunction with making the rules and regulations governing the system simpler, the government should seriously address the need for enhanced consumer education.”*

We agree that consumers would benefit from education regarding the processes and requirements of the auto insurance system. In addition, better education would be helpful for all participants in the system to increase trust and reduce disputes. Health professionals involved in providing care and opinion assessments require specific information regarding insurance regulations and system requirements. Insurers require education regarding common disorders resulting from auto injuries and effective treatments in order to make sound decisions regarding access to care and other benefits.

Disputes are frequently a result of competing expectations and/or misunderstandings of required processes by one or more parties. We are aware that health professional and insurer associations, as well as some other groups, provide educational opportunities. These have been helpful. However, they have not been sufficient.

There have also been examples of some shared educational opportunities, such as when representatives from the insurance community participate in workshops during health professional meetings. In the past under FSCO auspices, there were some multi-stakeholder educational programs developed with shared presentations and participation. Examples include the introduction of the Minor Injury Guideline (MIG) and the communication regarding the HCAI database and reports. These provided clarification and common understanding to better facilitate collaboration between the injured person, the adjuster, and health professional providing care to foster efficient, effective rehabilitation. Further ongoing multi-stakeholder educational programs and materials would be helpful to create trust and reduce disputes to foster efficient access to care.

The oversight and funding of multi-stakeholder education programs and materials should be provided under the auspices of an impartial body with multi-stakeholder (consumer, insurer, health professional, regulator) involvement. A multi-method approach should be developed and utilized to provide education to all stakeholders. This may include, for example:

- Written materials;
- On-line presentations;
- Videos and webinars;
- In person workshops for insurers and health professionals regarding programs of care;
- Reference guides; and,
- Communiques or bulletins to address common issues.

In addition, trustworthiness of opinion assessments would be increased by requiring better education and training of examiners. IE examiners must have a deep knowledge of the SABS tests they are applying and must be expert in the full range of relevant treatments for the population they assess. Disputes and demand for multiple competing examinations and associated costs would be reduced by requiring specific education and training for health professionals providing opinion assessments. There is already a model for certification of CAT assessors through a joint Canadian Society of Medical Examiners (CSME) / CAPDA program. This could create a basis for educational programs regarding IEs for other benefits, including for example, disability,



attendant care. Training in ethical and professional issues should also be a component. *(See further detail below in the solutions regarding IEs).*

***SOLUTION # 5: Provide specific education regarding the reality of psychological disorders and the role of robust psychological assessments to accurately determine diagnosis.***

Stakeholders have raised concerns regarding both over and under identification of individuals with psychological disorders. A solution is to provide specific education to all stakeholders regarding the real prevalence of psychological disorders following auto accidents and the role of robust psychological assessment to accurately determine diagnosis.

Over the years, there has been much criticism about the misuse of psychology to falsely identify individuals as having psychological disorders as a way to “escape the MIG” or other funding limits and to unnecessarily expand a claim. We are concerned that this notion has become a slogan used by insurers in their lobbying efforts to de-legitimize and disenfranchise those with psychological disorders. Repetition of this slogan has reinforced stigma against those with psychological disorders who most often are treated with skepticism. Too often, the insurer relies mistakenly on the severity of the physical injury to determine if there is a psychological disorder.

While we are aware that psychological disorders have the potential to be feigned or exaggerated, it is important to consider the science regarding what we know about the development of these disorders. Historically, psychological disorders were discounted and believed to be due to weakness of will or an effort to achieve some type of secondary gain. Contemporary science now recognizes that these psychological disorders are real and potentially disabling, much like cancer and heart disease. This recognition is now being incorporated in general social policy. It would be inconsistent with government policies, such as the recent and pending amendments to the Workplace Health and Safety Act related to traumatic and chronic occupations stress disorders, unreasonable, and regressive for auto insurance to treat those with psychological disorders in an inequitable manner.

A lack of appreciation of the reality of psychological disorders has led to inappropriate denials, and the intrusiveness and subsequent costs associated with IEs and disputes. These denials also cause transfer of costs to the public health system, which is already under resourced to provide for patients with psychological disorders.

Utilization of sound psychological assessment methodology includes validity measures. It provides and accurate diagnosis and identification of those who do have psychological disorders reliably, at a level that is at least as accurate as the diagnosis and identification of most physical conditions. Documentation of a psychological assessment and report of the results should increase insurers’ confidence in the trustworthiness of claims for psychological disorders. Therefore, it is reasonable that claims for a psychological disorder, which are accompanied by supporting psychological assessment data, be treated with the same trustworthiness as those for physical claims, and not subject to arbitrary or routine denial. Again, given a fairly widespread lack of understanding and awareness surrounding the realities of psychological disorders and disabilities, educating stakeholders about these issues is appropriate and should be required to achieve our joint goals of an excellent and cost-effective care delivery.

## **SOLUTION # 6: *Improve/modernize administrative procedures and forms.***

Minor changes to update and simplify existing forms and procedures will streamline injured persons' access to care. This would include modernization to take better advantage of paperless technology, including online and mobile applications. Reducing administrative burden would allow more focus on recovery of the injured person, as well as provide cost savings. A more "consumer friendly" process would increase trust in the system to foster recovery, reduce disputes and ultimately lower costs. At this time, many injured persons report their initial experience with the auto insurance system as intimidating and confusing. At the same time that they are upset by the accident itself and their injuries, they may feel challenged by the demands of the auto insurance system. At times, they report feeling overwhelmed and experiencing the process as conflictual rather than helpful. Improved efficiency and consumer service in the initial reporting processes will improve communication and trust.

Improving both process and content for form completion and submission would also reduce administrative and other non-care costs for both health professionals and insurers. A focus on relevant information would facilitate better communication. It also appears that some of the forms contain unnecessary, duplicative information, while others fail to provide adequate communication to facilitate adjudication and accountability. As an example, the assessment application and the treatment application were combined. This has reduced communication of useful information and has thus impacted on trust, resulting in more disputes and unnecessary costs. One option is to reintroduce separate forms. One form would address the reasons why a clinical assessment is required for the assessment application. A second form would address the findings, diagnosis, and recommendations for treatment. While we understand that forms were combined with the idea that this would create efficiency, it has only created further confusion and increased cost. Separate forms would be more efficient for the health professionals to use, and more useful for ease of review by the adjuster. They would also make more sense to the patient.

The assessment application should have better clarity regarding the clinical rationale for an assessment and a clear statement of the method for assessment consistent with health professional guidelines to improve accountability. The treatment plan application should have better clarity regarding focus on rehabilitation outcomes and increase accountability. An alternative solution would be to create specific dedicated subsections on a single "treatment" form if electronic formats are developed for these documents.

A solution is to engage appropriate experts with multi-stakeholder input to determine how to best update, and simplify the forms. Electronic versions of documents should be developed. Electronic versions of documents would facilitate better communication by employing required data fields. A "decision tree" approach would create drop-downs to be completed dependent upon data entered. Electronic versions of documents should also reduce administrative burden and the need for re-entry of static information. These improvements would increase trust, and reduce disputes and unnecessary transaction costs by providing more complete and relevant information regarding rehabilitation goals and treatment outcomes.

Future consideration should be given to determine which elements of the forms would be most useful to have as forced choice or pick lists of "data elements" that can be readily analyzed rather than entered as unstructured, free text fields. Inclusion of data elements in the forms could be used to build a searchable data base regarding auto accident injuries, treatments, and outcomes.

### **SOLUTION # 7: *Require use of a standard format for reporting treatment outcome.***

Regular and structured progress reports with data to document treatment outcome will assist adjusters in making informed decisions regarding the status of the injured person and/or the reasonableness and necessity of continued treatment. A solution to improve communication and accountability of health professionals providing care is to create and require use of a specific reporting format to report treatment outcome. This would include documenting treatment goals, interventions provided and rehabilitation outcomes. The signature of the insured person on this form would provide their confirmation of the description of their treatment and rehabilitation outcome.

If there is a need for further care; the continuing impairments, treatment goals, and interventions to be utilized would be described providing useful information to the insurer reviewing the application.

The reporting format for treatment outcome might be a separate form or separate section on an integrated “treatment” form. *(See above discussion re improving and modernizing forms)*

### **SOLUTION # 8: *Include the insured person’s electronic signature on treatment plans submitted to HCAI.***

At this time, the injured person is required to sign treatment plans and other benefit applications. However, the treatment plan submission process to HCAI does not support inclusion of the insured person’s signature. These are kept on file by the health professional. Many other systems have incorporated electronic signatures.

This capacity should be developed for the HCAI submissions.

Inclusion of the injured person’s signature would increase the insurer’s trust in the application by confirming that the insured person was fully aware of, and consenting to, the services and costs being proposed. This improved trustworthiness will lead to better ability to adjudicate the application with fewer denials, disputes, IEs and costs.

### **SOLUTION # 9: *Include “attachments”, for example, supporting documents and referral notes, on treatment plans submitted to HCAI.***

At this time, some forms submitted to HCAI may not have sufficient information for insurer decision making. There is limited capacity for “additional comments”. Supporting documents, such as referral notes and/or explanatory reports, *must be sent separately to the insurer* and only noted on the form submitted through HCAI.

This multi-step and disjointed process creates an additional administrative burden and costs for both health professionals and insurers. It also leads to confusion and poorer communication when the appropriate corresponding documents are not considered with the application. This current process also causes delays in the process, as the application is not considered to be at the complete stage and ready for the review process until the supporting documents are received by the insurer.

This solution builds on the usefulness of the HCAI system and provides more complete information exchange between the proposing health professional and the insurer reviewing the application. This shared information will improve the trustworthiness of the applications and improve the adjuster's informed decision making. This will lead to reduced disputes and less need for IEs with their associated costs.

### **SOLUTION # 10: Create a “System Navigator” or “Office of Driver Adviser”.**

Many injured persons find the auto insurance system process and associated paper work very challenging and turn to legal advisors. A “System Navigator”, who was perceived by all as an impartial resource, could provide assistance to understand the regulations and complete forms. While the system navigator or driver advisor would not direct care, make decisions about entitlement, or provide legal advice, it would reduce the need to rely on paralegal and legal services.

Creation of a resource that could be contacted by injured persons and/or their treating health providers if there is a question regarding expectations or processes to be followed that was viewed as both knowledgeable and impartial by all stakeholders would increase trust and prevent some disputes. An example would be questions regarding how to open a claim and what process needs to be followed to obtain treatment for an injury such as a whiplash.

To provide the necessary perceived trustworthiness, the service should be provided and funded under the auspices of the regulator or alternatively, an impartial body with multi-stakeholder involvement. There should be no charge to utilize these services to encourage utilization.

Implementation of a system navigator resource would require further investigation and development. The specific body to house the navigator system would need to be determined. The costing and funding would need to be determined. The qualifications and appointment process for the “navigators” would need to be determined. The effectiveness of the service would need to be evaluated through a pilot project including feedback from users.

### **SOLUTION # 11: Reinforce the “Patient’s First” approach to care.**

Access to care for those injured in accidents must be consistent with the government's policy and the direction taken by the Ministry of Health and Long-Term Care in its *Patient's First Act*:

*“...the commitment to put people and patients at the center of the system by focusing on putting patients' needs first. The first Action Plan for Health Care promised to help build a health care system that was patient-centered.*

*The “Patient First” approach to care is focused on the following attributes of a high functioning healthcare system:*

- **Access:** *Improve access – providing faster access to the right care.*
- **Connect:** *Connect services – delivering better coordinated and integrated care in the community, closer to home.*
- **Inform:** *Support people and patients – providing the education, information and transparency they need to make the right decisions about their health”.*

The “*Patient’s First*” approach incorporates the scientific evidence that patients recover more quickly when they have ability to make decisions about their health care and are able to access it without delays or barriers within their own community. This translates into the following:

- Protecting the patient choice of community-based treating health professional; and,
- Ensuring that the patient is empowered and informed to make decisions regarding their care together with their chosen community based treating health professional.

The solutions in this submission will provide mechanisms to reduce disputes. The centrality of the philosophy of Patients First and importance to clinical outcome of the health professional/patient relationship and patient choice in direction of their health care applies to all injuries.

The following proposals would be contrary to the research on effective health care and the “*Patients First*” philosophy and should not be implemented:

- Centralization of the provision of care;
- Limitations in the injured person’s ability to choose their community- based health professional for their treatment; and,
- Making Independent Examination Centers (IECs) or IEs “pre-emptive” or “binding,”.

The problematic nature of “pre-emptive” and “binding” assessments applies whether these assessments are done in private community-based facilities or in public hospital-based centers. Therefore, for ease of communication, we will refer to all of these assessments as IEs.

There are a number of reasons why a model of pre-emptive, binding IEs should not be introduced. These include:

1. ***A care model that requires Pre-emptive, gate-keeping assessments regarding diagnosis and treatment is clinically unsound.*** IE assessor(s) cannot be responsible for the provision of care to the injured person. The Report incorrectly assumes the IE is more reliable to accurately diagnosis and plan treatment than the treating health professional. This incorrect assumption unfairly disadvantages injured individuals by requiring attending an IE prior to obtaining care. In fact, the literature on evidence-based treatments documents that the engagement of the injured person in an ongoing process with their chosen treatment professionals is essential to accurate diagnosis and effective care.
2. ***A pre-emptive model will also create duplication.*** The treating health professional is bound by their professional standards to assess their patient and determine appropriate treatment prior to providing care. That requires, regardless of whether an IE has assessed the patient, that the professional diagnose a disorder and prescribe a plan for treatment.
3. ***A requirement for a pre-emptive IE also sets up a situation where there is significant risk of conflict and dispute*** when the treating health professional and the injured person come to a different opinion than the IE regarding diagnosis and/or treatment. These differences may be due to having one party having more information. In addition, there are usually multiple scientifically accepted diagnostic formulations and interventions in each case, leading to legitimate differences of opinion regarding

diagnosis and treatment. The treating health professional is required by the Standards of Practice of his/her regulatory college to assume the responsibility to exercise their expertise and judgment when providing care and cannot simply defer to the diagnosis and treatment plan provided by the IE. Therefore, the IE assessment regarding diagnosis and treatment cannot be “pre-emptive”, as further assessment must be then done by the treatment provider. An IE should only take place if the insurer has a question *after* assessment by the injured person’s community based treatment provider.

4. ***The IE opinion cannot be binding re: the correctness of the diagnosis and recommendations must be open to challenge.*** As discussed above, there may be legitimate differences of opinion. There will also be some instances where the IE appears to be biased or wrong for other reasons. It is naïve to assume that even the most qualified examiner is infallible. Either the insured person or the insurer must be able to obtain professional opinions to determine if there is a basis to challenge the IE opinion or recommendations. It appears the report recommends that only the LAT could allow a further assessment. In addition, this further assessment could only be another IE. This restriction would unfairly preclude either party obtaining the opinions they require to determine if there actually is a sound reason to disagree with the IE.
5. ***The IE cannot be binding re: future diagnosis and/or care needs must be open to ongoing determination.*** It is not possible for any assessment to be definitive regarding the future trajectory for diagnosis and treatment needs. Predictions can only be made for groups of injured persons but not at the individual person level. To hold an IE as binding for the future is incompatible with clinical science which clearly documents diagnosis and care needs change over time and in response to treatment. This change in symptoms and impairments, and response to interventions, requires the treating health professional to be responsible for on-going evaluation, monitoring and modification of care. In contrast, an IE is a “snap shot” in time. It can only provide recommendations the IE predicts will be effective, but cannot pre-determine the treatment outcome. Therefore, an IE evaluation can at best only be relevant to offer an opinion with respect the injured person’s condition and treatment proposals of the provider at a specific point in time. For the IE to remain current regarding the insured person’s condition, frequent repeated IEs would be required. This would entail insured patients attending repeated assessments by health professionals not responsible for their care. It would also need to be duplicated by ongoing work with their own treatment providers responsible for care. This results in delay, duplication, cost, and confusion - not more fair or better care.

While we cannot endorse the IEC model for the above reasons, our solutions address the Report’s goals to increase access to care for injured persons and to reduce the percentage of funds spent on costs that do not provide services to foster recovery such as Insurer Examinations (IEs). Our solutions maintain and improve an Accident Benefits system whose values and processes are consistent with Patients First and fairness as described above.

**Solution # 12: Allow all insured persons access to initial funding for care without being subject to insurer denial or IE. Eliminate insurer denials and IEs for all care applications under a pre-determined dollar threshold and initial time period. (dollar value and time period to be determined).**

Automatic access to a specified amount of funding over a specified time period, without insurer denial or IEs would allow more funds to be applied directly to treatment rather than spent on costs that do not contribute to care, such as IEs. The automatic approval of funding for care without dispute should not be limited to services provided within the MIG or POCs.

The large number of IEs and high proportion of costs relative to the funds spent on treatment is documented in the data report from the Ontario Health Claims Database (HCDB) Standard Report, 2016 – H2, published by the Insurance Bureau of Canada included below. The proportion of IE costs is particularly striking for the claims with lower dollar value. It appears to be around **30%** of the total costs. Unfortunately, missed/cancelled appointments are an additional component of IE costs. In contrast, the proportion of IE costs for larger claims drops significantly to around **9%**. Therefore, eliminating insurer denial and IEs regarding medical and rehabilitation benefits under a certain threshold would ensure that a greater proportion of funds were used for treatment rather than on IEs that do not provide care. At the same time, allowing insurer denials and IEs over this threshold would maintain insurer control over larger expenses.

Approval for medical and rehabilitation services should be automatic on notification to the insurer as long as certain criteria are met and required forms are completed. (*Criteria to increase accountability and trustworthiness of health professionals are described in later sections*). This would facilitate more rapid access to care, more effective and direct utilization of funds for care, and lower costs by eliminating these IEs. In addition, it would remove the air of animosity and distrust between the insurer and the injured person that often results from insurer denial of treatment applications. (See Appendix 1, *Percentage Distribution of Expense Class by Medical and Rehabilitation Expense Range and Accident Date from Ontario Health Claims Database (HCDB) Standard Report, 2016 – H2, published by the Insurance Bureau of Canada*)

**SOLUTION # 13: Update the current MIG Guideline and/or develop POCs for those with minor injuries/CTIs.**

We agree that Programs of Care (POCs) can be useful to facilitate efficient and timely provision of evidence informed care to a large percentage of injured individuals with the most common injures, resulting from auto accidents. This is seen in the extremely high utilization of the Minor Injury Guideline (MIG). We note that approximately 80% of injured persons receive treatment in the MIG.

POCs can provide many benefits for initial treatment of injured persons with common soft tissue injuries, such as:

- Streamlining access to evidence informed care;
- Creating shared expectations;
- Reducing administrative burden;
- Improving trust;

- Reducing disputes and costs; and,
- Fostering efficient recovery.

The effectiveness of the POCs is dependent upon incorporating a clear understanding that a POC can provide guidance regarding generally recommended treatment for disorders but is not prescriptive at the individual patient level. Treatment of the individual patient is the responsibility of the treating health professional. The specific treatment provided to the individual patient is dependent upon the assessment and clinical experience, training and expertise of the treating health professional and must also consider the preferences of their patient. Thus, the POC should describe a basket of evidence informed services for a period of care, but it is not a prescriptive treatment protocol. A POC also must not be confused with a diagnosis-based cap on funding for care, as all research shows that a subset of individuals will not be sufficiently recovered and will require care beyond the POC.

Significant investment has been made and research was completed on evidence-informed treatments for Common Traffic Impairments (CTIs). In addition, the Pre-Approved Framework (PAF) and the MIG have provided experience with utilization of block or phase of care approach to provide evidence informed treatment for those with soft tissue injuries. *(See discussion of Type I and Type II injuries in later solution, Introduce explicit criteria for insurer approval of funding for treatment planning assessment for injured individuals with non MIG/non CTI injuries)*

A solution to accomplish this next step to update the MIG or develop POCs based on the CTI research is to establish a multi-stakeholder working group, including representation from the treating health professional associations, to translate the research into an updated MIG or CTI POCs. This group will need to determine appropriate fee structure for health professional time required to provide effective treatment. The fee structure will need to incorporate additional funding for patients who require services of multiple pathways. Trust will be increased and needless disputes, multiple assessments and unnecessary costs avoided through minor improvements in the reporting forms and processes for further care within the MIG/POCs.

#### **SOLUTION # 14: *Increase or remove the minor injury funding cap.***

There has been no adjustment in the minor injury fee cap benefit level since 2010, which is an actual reduction in 2017 dollars. The care pathways in the Cote report on Common Traffic Impairments (CTIs), describe care for more injuries and over a longer time period than the current MIG. If a cap on the level of funding for the treatment of injured persons with “minor injuries” or CTIs is maintained, the level of funding must be revisited and appropriately increased annually based on inflation, improvements/changes in evidenced-based care delivery, etc.

A realistic increase in the fee cap will improve access to care when needed to foster recovery, increase trust, reduce disputes, and lower costs. By providing an increase in the level of funding for those who require relatively small amounts of additional care beyond the current \$3500.00, further disability and care costs are reduced. An increase in the minor injury cap would also reduce transaction costs associated with disputes regarding ability to access additional funding even for small amounts. Utilization data may assist in determining of a realistic increased level of funding.



Removing the minor injury funding cap should also be considered. It may appear counterintuitive to remove a “cost control” measure. However, conflict inherent in the current process for accessing even small amounts of additional treatment increases costs to the system without contributing to care. Currently, the focus is not on whether the proposed care is needed, but on whether the insured crosses a threshold. Removal of the Minor Injury Cap eliminates these disputes over minor/not minor injury status. This recommendation is consistent with a focus on injured persons receiving needed care, which is a cornerstone of the Report. It is also consistent with the findings of the Dr. Cote research, that some injured individuals have poor recovery and require further treatment to restore function. Removal of the cap should be accompanied by more clarity regarding POCs for needed care for those who have a poor or delayed recovery and would likely benefit from modest additional care.

***SOLUTION # 15: Introduce explicit criteria for routine insurer approval of funding for treatment planning assessment without requiring an IE for injured individuals with non MIG/non CTI injuries.***

We agree with the Report that utilization of the MIG/CTI streamlines access to care for the majority of injured individuals by providing for the initial care for individuals with common soft tissue injuries. The MIG/CTI POC includes assessment and treatment services. However, there are some individuals for whom it is readily apparent that their injuries are not within the MIG/CTI framework. In his research paper regarding Common Traffic Impairments (CTIs) Dr. Cote describes these as Type II injuries.

Unlike those patients with less serious injuries (Type I who are in the MIG/CTI), patients with Type II injuries, including those with psychological disorders, currently do not have access to any treatment without insurer approval. Thus, those with the most serious injuries and disorders have the least freedom to use initial treatment funding that they and their health professional determine is appropriate. We agree with the Report that it would be helpful to improve the process for access to care for injured persons with these disorders. We provide solutions to address some of the barriers.

Dr. Cote describes ***Type I*** injuries as addressed within the CTI, in contrast with ***Type II*** injuries that are not addressed within the CTI. Dr. Cote states the following:

***General Approach to the Management of Type I injuries***

*As an overview, therefore, we propose that a consistent approach be adopted to manage Type I injuries over the entire course of their recovery process. The management should include education, advice, encouragement to stay active (including return to work), and reassurance that Type I injuries and their associated distress and discomfort are usually of a time-limited nature. Health care professionals should discuss with the injured person the range of effective interventions available for the management of their injuries. Supplementing self-management strategies with clinical care may be indicated for Type I injuries provided the intervention is likely to enable recovery through symptom relief and improvement in function.*

***Type II Injuries***

*Type II injuries typically involve a substantial loss of anatomical alignment, structural integrity, psychological, cognitive, and/or physiological functioning. The majority of patients with such injuries*

*will require (in addition to natural healing) a significant amount of medical, surgical, rehabilitation, and/or psychiatric/psychological intervention to ensure an optimal recovery. There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns. Examples of traffic collision-induced Type II injuries include fractures of the femur and hip, shoulder dislocation/fracture, facial fractures, depression or post-traumatic stress disorder. The management of Type II injuries is not within the scope of our report.*

There are other individuals who may initially appear appropriate for treatment within the MIG/CTI, but who are found to have symptoms of physical, cognitive or mental disorders not addressed within the MIG/CTI. The Care Pathways described by Dr. Cote all include the direction to the treating health professional to monitor and refer for further assessment/treatment when there is incomplete recovery or concern regarding physical, mental or psychological symptoms.

Insurers have a high level of distrust and frequently deny applications for assessments to plan treatment. This leads to frequent IEs and disputes. A solution is to create clear criteria to improve the trustworthiness of the application. These criteria would be the basis for the insurer to routinely approve assessments to plan treatment by the insured person's chosen community-based treating professional(s) without requiring an IE. These criteria would formalize and standardize the process. Clear criteria that are easily understood and followed would improve trust, provide more efficient access to care, reduce disputes and lower costs. This solution is in accordance with the "Patients First" approach, described above: the injured person should be able to attend the community based health professional of their choice to diagnose their condition and develop a treatment plan for them to consider.

The criteria we are suggesting are for psychological assessments to plan treatment for injured persons presenting with symptoms of psychological disorders. Criteria could be developed for other disciplines if required for addressing other types of disorders.

The criteria to routinely approve psychological assessment proposals without requiring an IE include the following:

- A referral to a treating community-based psychologist based on need identified by the practitioner providing a program of care for soft tissue injuries (MIG /CTI); or by the family physician or other treating health professional;

OR

- By the patient and supported by a practitioner a providing program of care for soft tissue injuries (MIG /CTI); by the family physician or other treating health professional;

AND

- Confirmed by screening by the treating community based psychologist including completion and reporting of standardized screening psychological measures, if clinically appropriate;

AND

- The assessment to be provided consistently with guidelines for: inclusion criteria, assessment and treatment process, reporting requirements and fees are followed.

The above criteria for insurer approval of assessments to plan treatment will improve the applications and insurer's ability to trust the legitimacy of the proposals they receive for assessments to plan treatment. This has been a particular concern for patients with psychological injuries where there has been a high level of suspicion about these applications. Improving the trustworthiness of the applications will reduce the high frequency of denials with the associated disruption to treatment and costs of IEs.

When there is no referral and/or support from the family doctor or other treating health professional, the insurer should use their discretion when reviewing the proposal and not arbitrarily deny the application. If the insurer has questions they should discuss with the insured person and the proposing psychologist. If these questions are not resolved the insurer should only then obtain an IE.

### **SOLUTION # 16: Increase communication between insurers, health professionals and the insured person.**

We agree with the focus in the Report on increased communication as a way to improve trust and reduce disputes. A solution is to make minor changes in processes, creating clear expectations for health professionals who are proposing the treatment plans and insurers who are reviewing them, and for increased direct communication between the injured person, the insurer and the health professional.

A more collaborative approach for preparation and adjudication of applications for care should allow more accurate determination of when an IE is required by the insurer, reducing the number of these examinations and costs. This will limit need for IEs to when the insurer has a basis to question the diagnosis or treatment recommendations of the person's treatment provider.

Minor changes in processes to improve communication and clarify expectations may include:

- An expectation that health professionals will indicate if the treatment proposal is consistent with professional guidelines;
- An expectation that treating health professionals will attempt to contact the adjuster when proposing a treatment plan that is an exception to professional guidelines to provide the explanation;
- An expectation that adjusters will attempt to contact the proposing health professional if they have a question regarding proposed treatment prior to denying the plan;
- Encouraging insurance companies to consider engaging Health professional advisers to assist adjusters in house if they have questions regarding treatment proposals. These in-house health professionals could also facilitate communication between the health professional and the adjuster;
- Providing continuing education for health professionals regarding the requirements of the insurance system. Insurance adjusters should receive ongoing education regarding common injuries, disorders that occur as a result of the injuries or other factors related to the collision, various treatment modalities, etc.; and,
- Problem solving forums and Q and A's addressing common issues would be helpful to improve common understanding and trust.

A multi-stakeholder working group, with representation from the health professional associations, could develop specific recommended processes, forms and educational materials to support the implementation of this solution. One component would be confirmation of the completion of the required communication

expectations on both the application and the insurer's response to the treatment proposal so that compliance could be monitored.

**SOLUTION # 17: *Include case management as a potentially available accident benefit for all injured individuals. Remove the restriction of case management to those who have been determined to have a catastrophic impairment.***

The injured person should be able to select a health professional to function as a case manager to assist them in managing their treatment and rehabilitation services. This benefit should be subject to the same application and approval processes as other medical/rehabilitation benefits.

**SOLUTION # 18: *Require health professionals to confirm that treatment plans are consistent with standards of practice and treatment guidelines.***

As discussed above, POCs provide useful administrative mechanisms for access to care for those with MIG/CTI conditions. However, as noted, POCs are less applicable for those with more serious injuries, such as those described as Type II by Dr. Cote cited above. This does not mean that health professionals are not accountable for their work when providing care outside of POCs.

In fact, regulated health professionals are expected to provide care that is evidence informed, consistent with health professional regulatory standards and health professional association treatment guidelines. As an example, psychologists are regulated by the College of Psychologists of Ontario and must comply with the College Standards of Practice. In addition, the OPA has published assessment and treatment guidelines relevant to individuals injured in auto accidents. (*These guidelines are available on request*).

There are common expectations of treating health professionals that arise from standards and guidelines. For example, an approach to treatment that is consistent with standards and guidelines includes:

- Use of comprehensive process and symptom measurements (*when clinically appropriate*) with the goal of demonstrating whether treatment is working;
- Modification of treatment plans according to outcome;
- Provision of regular documentation regarding progress; and,
- Continuation of treatment if:
  - 1) the person remains symptomatic and treatment is being shown to work; or,
  - 2) the person remains symptomatic and there are clinical indications that taking treatment away will result in meaningful deterioration, or,
  - 3) the person is working on rehabilitation/return to function goals that are not yet achieved and continuing psychological services are needed to move forward.

Regular reports and forms with data to document progress will assist adjusters in making informed decisions regarding the reasonableness and necessity of continued treatment.

Improved forms (as discussed above) will include statements to confirm consistency with standards and guidelines. The forms which require reporting of the above content will facilitate better communication. This

will improve accountability of the treating health professional which supports more trust; reducing disputes and the frequency IEs, and lowering costs.

***SOLUTION # 19: Improve the mandatory report of paid expenses by making it more frequent and informative.***

This expense report can be a very useful tool for the injured person and he/she should be provided with access to the reports. It helps the injured person to be in a better position to manage their health care expenses. However, the current report is not sufficiently timely and does not provide sufficient information.

A solution to build on the current process would be to make the report available on a monthly basis. In addition, the report should be modified to provide specific information regarding services invoiced and payments to each health professional seen by the insured person.

It would be beneficial to include a direction to the insured person to contact the insurer and/or the health professional if they have any questions about the charges that are reported as paid.

For future consideration, it would be useful for insured persons to have electronic access to view the amounts that have been paid for their services in real time.

***SOLUTION # 20: Implement the Provider ID tracker to increase trustworthiness, and reduce costs associated with professional identity fraud.***

The Professional Credential Tracker has been a project with multi-stakeholder involvement that identified instances of provider identity fraud. The data showed that there were some facilities billing for services of health professionals who were not really associated with those facilities. This identification would allow for remedial action.

A solution to further increase the trust in health professionals is to expand on the pilot project to allow health professionals to readily check on the use of their credentials and report any misuse to the appropriate authority. In addition, the usefulness of the Professional Credential Tracker as a resource to injured persons and insurers to verify the professional credentials of those who are providing care within a facility should be explored.

***SOLUTION # 21: Expand the use of the FSCO licensing of all health facilities to address concerns regarding outlier behaviour***

A recent initiative following the anti-fraud task force was the introduction of licensing of health facilities billing auto insurers through HCAI. This licensing process includes onsite audits to confirm compliance with the regulations. We understand that since the introduction of this process there has been a significant reduction in the number of facilities.

This FSCO process is required in addition to health professional licensing and registration through the various health professional colleges and regulatory bodies. The FSCO licensing process required considerable

investment of time and cost by health professionals. There is a significant licensing fee as the system operates on a cost-recovery basis. There is an annual submission and fee required.

The audits have been conducted both on random and risk-based bases. We understand that, over time, there has been improvements in compliance.

Greater benefit can be derived from this FSCO licensing system. A number of solutions to improve accountability and trustworthiness of health facilities could be implemented within the structure already in place with the FSCO licensing system. These include:

- Making facility data available on-line to the public, including their rostered of health professionals;
- Requiring the facility director to confirm, all health professionals in the facility maintain good standing with their health professional regulatory body and have satisfied all the requirements for continuing education in the Annual Information Report(AIR); and,
- Conducting more targeted audits when there is a question or concern about a specific facility. A targeted approach to identify and address outliers is preferable to building a system based on generalized distrust. We understand that there may be applications of the Professional Credential Tracker that will be useful to highlight facilities that should be more closely examined.

We support more fully utilizing the FSCO licensing process as a mechanism to increase the trustworthiness of health professional facilities. It is unnecessary and would be highly disruptive to service delivery to require additional certification such as The Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. Any such additional requirement would inappropriately disadvantage sole providers and small group practices that are preferred by many injured individuals. It would shift the provision of care to large institutional settings.

***SOLUTION # 22: Ensure that Fee Schedules for SABS Benefits are sufficient to maintain a sufficient supply of health professionals to treat injured individuals.***

We agree with the report that fees for medical and rehabilitation services provided through Accident Benefits should be reasonable.

There is a Professional Service Guideline (PSG) fee schedule that provides maximum hourly fees for various health professions and describes caps on fees for assessments and examinations. The PSG has been in effect since approximately 2003. The last increase in the fee schedule was approximately three years ago and the fees are not yet at the level they were in 2001.

The Marshall Report recommends consideration of the WSIB fees as a compensation model. We are aware of recent increases in WSIB fees as there has been a shortage of health professionals able to provide services under their highly restrictive fees. It is also relevant to compare fees paid by auto insurers to fees paid in other contexts, such as other payers of hourly fees for services, as well as salary compensation. For some health professionals, auto insurance payment is only approximately 2/3 of their recommended hourly fee or other compensation rate.

A solution for an improved payment model for initial care for most injured individuals with soft tissue injuries would be to involve the relevant health professional associations in setting the fees for an updated MIG/CTI. The fee must be set at a level not to be a disincentive to provide these services. Similarly, the hourly fees for services outside of the MIG/POCs are reviewed on an annual basis and should reflect increases in costs of providing care (health care inflation) and the range of payment provided by other payers.

Requirements for experts conducting Tort assessments are distinct from those for providing services under Accident Benefits. Health professional regulatory colleges have standards for their members regarding required processes for establishing their fees for this type of work. There is also a process wherein the Courts may be asked to “tax” an expert’s fee to determine if it is reasonable. However, a fee schedule such as the PSG would be entirely inappropriate in the context of Tort fees given the great diversity of services sought and unique knowledge and experience of experts and requirements of each case in the tort system.

### ***SOLUTION # 23: Determine if there is a mechanism to better facilitate return to work.***

Injured individuals face a number of barriers in return to work which interferes with their recovery.

A solution would be to explore if there is a mechanism to address the barriers created when individuals injured in auto accidents are told by their employers that they must be 100% prior to returning to the work place, with employers reserving positions with modified duties only for those injured in the work place.

### ***SOLUTION # 24: Retain cash settlements of Accident Benefits.***

The LAT is explicitly intended to make dispute resolution more timely and efficient. It is our impression that treatment questions are being addressed very quickly. Thus, the LAT resolves issues of timely access to necessary treatment rather than cash compensation at a later date. Fewer disputes and timelier dispute resolution to provide funding for treatment will reduce the number of injured persons seeking cash settlements of their treatment benefits. While we agree with the focus in the Report on “care not cash”, cash settlements should not be precluded.

There will be some instances when either the insurer and/or the insured person determine that it would be preferable to close the claim and settle the benefit. In these instances it should be permissible to propose a settlement. Cash settlements allow the insured person to determine how they wish to use the funds to pay for their care. In addition, cash settlements often are used to pay health professionals for necessary care that has been denied by the insurer and/or to pay other debt the insured person has incurred to pay for necessary treatment when the insurer has denied funding. For some individuals, involvement in the Accident Benefit (AB) system with insurer denials results in increased stress, anxiety, etc. Cash settlements allow them to have control over their AB dollars and often result in increased self-efficacy, more active engagement in their rehabilitation, and improved functioning.

## **Section 2: To improve the quality and trust in Insurer Examinations (IEs) and to reduce disputes and “competing opinion examinations”**

### ***Solution # 25: Provide ongoing evaluation and resourcing to ensure that the LAT achieves its mandate to resolve disputes about care in a more efficient and timely manner.***

After a long and intensive review and consultation process, Justice Cunningham produced recommendations that are referenced in the Report. Many of the Cunningham recommendations just now coming into effect, including the establishment of the LAT. The LAT is explicitly intended to make dispute resolution more timely and efficient, as well as less costly.

The rules of the LAT now set expectations to:

- Restrict many hearings to paper reviews;
- Restrict the duration of the hearings;
- Reduce the number of experts to be called; and,
- Reduce the length of reports.

These measures will result in significant cost savings, reducing the number and costs of competing assessments, as well as costs associated with testimony in hearings.

Ongoing evaluation of the LAT is essential to achieve these objectives. The evaluation should include data regarding outcomes and timelines for resolution of disputes and incorporate feedback from all participants. The results of the ongoing evaluation should be published as semi-annual publicly available status reports. Such ongoing evaluation is essential to ensure that sufficient resourcing is provided and necessary modifications are made to the LAT processes.

### ***SOLUTION # 26: Create an enforcement mechanism that incorporates the LAT requirement for experts to provide opinion evidence that is “fair, objective, and non-partisan”.***

We agree with the Report’s view that the LAT can be an effective mechanism to reduce the number of disputes and lead to more efficient resolution. The rules of the LAT now require all experts to certify that they will, “*provide opinion evidence that is fair, objective, and non-partisan*” with a duty to the trier of fact. Assessor evidence that does not meet this standard will not be allowed. This will improve trustworthiness of IEs by eliminating assessors who are found to be unfair, lack objectivity, or conduct their assessments in a partisan manner. Publication of LAT decisions, including the information the LAT has rejected an expert’s opinion for these reasons will limit the use of these experts. Risk of such exposure will also cause those experts who may have been insufficiently sensitive to issues of perception of bias to take greater care in their work.

Sanctions and consequences for experts who are found to provide opinions that are not “fair, objective and non-partisan” should be developed. Findings of failure to provide fair, objective non-partisan opinion by a



judge or adjudicator should trigger an automatic referral for investigation by the relevant health professional regulatory body. The findings of the investigation of the regulatory body and any discipline or suspension should be published by the respective colleges. The existence of this formal procedure will result in improvement of the quality of IEs and significantly reduce the participation of biased assessors in the system.

We understand that there are particular concerns regarding the perceived reluctance of the College of Physicians and Surgeons of Ontario (CPSO) to take on the task of examining bias in independent medical examiners. Further consultation with the CPSO, and other health professional regulatory colleges will be required to develop more efficient and responsive processes to address these complaints.

Similarly, there should be sanctions and consequences for insurers who engage examiners to provide opinions who they “*should have known*” are not “*fair, objective and non-partisan*”. For example, it should be considered if this is an instance of “*bad faith*” and warrant compensation to the injured person.

**SOLUTION # 27: *The insurer shall offer the insured person five IE examiners/facilities from which the insured person will select one.***

We agree with the Report that there should be improvements to the IE system to increase real trustworthiness and the perception of trustworthiness. A concern regarding the trustworthiness and acceptance of opinions from IEs tends to be anchored in the perception that some IE examiners may be biased. While requiring standards for qualifications and for examination processes will accomplish a great deal to restore confidence, allowing the insured person some “veto” power will further support the process of improving trust. This can be accomplished with a simple modification to the current process.

The following is an illustration of how insured person “choice” could be implemented without a fundamental change to the system of IE examinations:

- An application for med-rehab benefits or other benefit determination is submitted to the insurer;
- The insurer determines that they are not prepared to approve the application and requires an IE;
- The insurer provides notice to the insured person that they require an IE;
- The insurer provides names of 5 IE facilities or individual examiners to conduct the examination;
- The insured person responds within 5 days, selecting 1 of the 5 proposed facility/assessors to conduct the examination;
  - The insured person would be able to review the facility health professional roster on line as reported in the facilities FSCO license;
  - If the insured person fails to respond, the insurer would select the assessor to conduct the examination; and,
- The insurer then books the IE with the selected facility/examiner.

Specific operational details would be developed by a multi-stakeholder working group.

**SOLUTION # 28: *Require all IE examiners meet standard assessor qualifications.***

A further solution to achieve the Report’s goal of increasing the trustworthiness of examinations will be to impose standard assessor qualifications. The quality, credibility, and trustworthiness of IE opinions are largely

dependent upon the professional skill and competence of the examiners. Therefore, a key solution to improve the IEs is to create a set of assessor qualifications that must be met by all examiners, whether working in a small community-based practice, a large IE company, or in a hospital-based facility.

Required qualifications could include:

- Documentation of member status in good standing of a health professional regulatory college;
- Certification of completion of training requirements;
- Documentation of participation in relevant health professional continuing education;
- Demonstration that the examiner’s practice includes providing treatment to patients with the same conditions, if providing opinions regarding treatment plans;
- The examiner is a member of the same health professional discipline as the health practitioner proposing the treatment plan, if providing an opinion regarding a treatment plan; and,
- Membership in an Ontario professional organization that has issued guidelines for assessment under MVA.

A solution is to require, that if a facility completes IEs, the director certify that all rostered health professionals meet these qualifications in their Annual Information Report.

Regarding certification of IE examiners, The Canadian Academy of Psychologists in Disability Assessment (CAPDA) and the Canadian Society of Medical Evaluators (CSME) recently jointly introduced a two-day training workshop for assessors who conduct catastrophic determination assessments. These two organizations have also recently introduced the CAPDA-CSME C-CAT Certification, a catastrophic assessment certification program whereby participants must complete the aforementioned training and then challenge written examinations in order to be certified as either physical, mental-behavioural, or functional catastrophic assessors.

CSME/CAPDA are already in the process of creating programs for additional types of IEs. (*Further information in regard to these programs can be made available upon request*). Similar programs could be developed for IEs regarding other benefit determinations.

### **SOLUTION # 29: Require that all IE assessments follow standardized assessment processes.**

We also agree with the Report’s goal of increasing the acceptance of findings and opinions of examinations. The quality, credibility, and trustworthiness of IE opinions are also dependent upon the processes employed for completion of the examination and the reporting of the findings and opinion. Therefore, a solution to improve the quality, trustworthiness and usefulness of all IEs is to require standardized processes and assessment guidelines, whether working in a small community based-practice, a large IE company, or in a hospital-based facility.

Assessment Guidelines do not replace the professional judgement and responsibility of the individual health professional. However, they will create a more uniform approach and reduce variability to increase confidence and trust in the opinions.

Compliance with required guidelines could include for example:

- A standardized work flow describing the referral, examination and reporting process;

- Standardized time lines for completion of the examination and report; and,
- Standardized reporting formats.

An example of a guideline that has been developed is the recently published “***OPA and CAPDA Guidelines for Best Practices in Insurance Examinations***”. This is a comprehensive document that provides consensus advice, representing both treating psychologists and psychological insurance examiners regarding fair, balanced, and evidence-based methodologies for conducting psychological insurance examinations. While this document was written for psychologists, a large portion of it is relevant for insurance examiners of all professions. It could be used as a springboard for the development of best practices guidelines for other professions and/or professionally neutral IE Guidelines. *(Available on request)*

***SOLUTION # 30: Retain the model that allows IEs be delivered by private community-based facilities, large IE companies, or by hospital-based facilities (i.e, Do not require IEs to be hospital-based or centralized).***

We agree with the Reports goal of improving the quality and trustworthiness of IE examinations. However, this is best addressed through addressing assessor qualifications, assessment processes, and guidelines; and introducing the involvement of the insured person in the selection of the IE examiner. Requiring IEs to be hospital-based does not address issues of expertise, impartiality, and quality control to improve trustworthiness. It will cause disruptions in the current system that will introduce a number of negative consequences. The location of the assessment does not determine if the assessor is expert, unbiased, and objective.

Requiring IEs to be hospital-based would place an additional burden on already over extended hospital resources. In addition, there is a lack of appropriate expertise in many hospitals to provide assessments and recommendations regarding rehabilitation. With an emphasis on early discharge, rehabilitation is rarely found to be a focus of hospital mandates. Therefore, the hospitals will be seeking to hire the same professionals currently practicing in the community or working for IE companies. Requiring IEs to be hospital-based also places an additional burden on the injured person. If the local hospital does not have these services, they will be required to travel to attend assessments located at hospitals at a distance, rather being seen by community-based providers.

In addition, we have heard that many community hospitals are not willing to take on this adjudicative/medical legal role that is completely outside of their mandate to provide care to those who require hospital based services. We note that these types of assessments are an increasing area of complaints to professional colleges and professional liability insurers.

Some have suggested that hospital based IEs would be a mechanism to provide additional funding to hospitals and reduce costs. However, there is no basis to suggest that hospitals would be able to provide more cost effective examinations than is currently being provided in the private sector where there is significant competition leading to reduced costs. In addition, given that hospital resources for both personnel and space are already over taxed, conducting the IEs would require additional expenses which would absorb any fees paid for these services. In summary, hospital based IEs will result in injured persons waiting longer to see less qualified assessors.

IE assessments also should not be limited to a small number of large facilities. Allowing multiple types of settings, and only restricting participation by requiring qualifications and adherence to guideline practices, will foster timely and convenient access for the injured person. It will avoid the bottlenecks inherent in a more monopolistic system. Openness to multiple types of arrangements for provision of IEs will also encourage completion on quality and price.

***SOLUTION # 31: Allow an IE only when the insurer has a reason to question an application from the insured persons health professional(s) ( i.e., Do not make IEs “pre-emptive”).***

We agree with the Report that there are too many “competing assessments” are completed now. However, we do not agree with the Report’s recommendation that IEs “pre-empt” clinical assessments by the injured person’s own treatment providers to plan care. This is entirely inconsistent with health research and the Patients First approach. Patients First (as discussed above) and research on evidence based care emphasizes that the patient working with their chosen community based health professionals to make decisions about their care, leads to optimum outcomes.

There are many problems inherent in the suggestion that the IEs would pre-empt assessment and treatment planning by the injured persons treating health professional(s). A model of pre-emptive IEs would create needless duplication and additional cost. The treating health professional is required by the standards of their health professional regulatory body to conduct an assessment to determine impairment/diagnosis and plan treatment prior to providing care. It would be professionally irresponsible to provide the care based on the diagnosis of the other examiner. Similarly it is professionally inappropriate to provide care that the community health professional had not determined was appropriate for their patient considering the patient’s needs and preferences.

Rather than reducing the number of IEs and costs of services that do not provide care; pre-emptive IEs would lead to increased distrust and dispute, competing assessments, and increased costs. Within the model of pre-emptive IEs, all injured persons who wish to receive any care outside of the MIG/POC would be required to have one of these assessments. The IE could not replace but would need to be followed by an assessment by the treating health professional. This creates two assessments for every person, every time a person is seeking further care. Conversely, retaining a system where the patient is able to obtain an assessment, diagnosis and care plan from their treating health professional limits the additional costs of IEs to those situations where the insurer has a basis to question the diagnosis and/or treatment plan.

***SOLUTION # 32: Provide opportunity for the insured person to obtain opinion from their health professional(s) if they disagree with an IE. Do not make IEs “binding”.***

As noted above, we agree that the number of “competing assessments” should be reduced and offer a number of solutions to increase the acceptance of examination findings. However, it is scientifically incorrect to make the IE assessment “binding” regarding diagnosis. The treating health professional is legally responsible to determine the diagnosis and determine treatment prior to providing care and cannot defer to the opinion of the IE.

It is incorrect to assume that the IE can be definitive about treatment even when there is agreement on diagnosis. There are very few individuals who have a single condition where there is a single evidence based treatment protocol that is applicable to all patients. Evidence based patient care always requires considering the full patient and patient involvement in decision making considering the expected benefits and known risks of various treatments. Therefore, these care decisions must be made on an ongoing basis by the injured person together with their treating health professional(s). A core component of all care is meeting with the patient and discussing the pros and cons and potential benefits and risks of various treatments and then having an ongoing dialogue. This is consistent with the *Patients First* philosophy. An IE cannot do this.

The IE opinion is a snapshot in time with inherent limits of certainty, potential for error, and cannot be binding for ongoing care decisions. The IE cannot take into account the need for on-going monitoring and evaluation, and responsibility for modifying diagnosis and care plans in response to treatment.

***SOLUTION # 33: Utilize “peer review” and consultation between health professional peers to address differences of opinion to improve quality and efficiency of IEs regarding care.***

We agree with the Report that it is important to make examinations more credible so that the opinions are more likely to be accepted by all parties resulting in fewer “competing assessments”. The solutions described in previous sections requiring adherence to guidelines and standards in clinical assessments and treatment proposals will increase the trustworthiness of applications. When the insurer has questions regarding these and requires an IE, the following process will be more efficient, less costly and better contribute to dispute resolution.

IE assessments regarding treatment plans should only occur when the insurer has a specific question about a treatment plan that has been submitted by the insured person’s treating health professional. That is, the IE should not pre-empt an assessment to develop a plan for care by the insured person’s treating health professional(s).

When required, these IEs should be done in an efficient manner so as not to create a delay in access to care or excessive additional costs. (See above re insured person involvement in the selection process).

The following processes are recommended for IEs regarding treatment applications:

- The insurer should be required to indicate their specific questions about the treatment proposal and not merely assert that it is not “reasonable and necessary”;
- The assessment would be completed by a practitioner of the same discipline as the proposer who certified the treatment application. This will increase credibility and reduce the need for multi-disciplinary teams. In specific situations, and only if the principal assessor determines the need would the assessment include additional assessors of other disciplines. The practitioner of the same discipline as the proposing practitioner has the most appropriate education, training and experience to carry out the assessment; and,
- The IE examiner would be expected to communicate with the proposing health practitioner if there are questions or areas of disagreement. Communication is imperative to increase the trustworthiness of the system. These discussions provide an opportunity to develop a shared understanding and to prevent disputes. Funding for this communication should be provided because communication is

essential and funding acknowledges the importance of this activity to reduce disputes. The cost of these discussions would be less than the costs of disputes prevented.

**SOLUTION # 34: *Faciliate a more collaborative process to address differences between the treating health professional and the IE examiner prior to proceeding to dispute regarding care.***

As stated above, we strongly agree with the Report that it would be beneficial to avoid and more efficiently resolve any disputes. A mechanism to address differences in diagnosis or treatment recommendations between the treating practitioner and the IE should be developed. If the treating practitioner does not agree with the opinion of the IE, they will be encouraged to try to communicate with the IE assessor to determine if they can resolve areas of disagreement prior to the injured person proceeding to dispute. Funding should also be provided for this communication. The cost of communication will be more than recovered by avoiding further competing assessments and disputes. If this communication results in a modification of the IE opinion, documentation of this is required.

In those instances where it is not possible to collaboratively resolve questions regarding diagnosis or treatment, the matter should rapidly proceed to dispute resolution through the new LAT processes to challenge the opinion assessment diagnosis and/or recommendations so that timely care can be provided if it is found to be reasonable and necessary. We assume the LAT process would address the issue regarding treatment by review of paper submissions from the parties to the dispute.

### **Section 3: Catastrophic impairment, settlements, and tort and legal representation**

**SOLUTION # 35: *Do not change the CAT definitions.***

We agree with the Report that the Catastrophic Impairment criteria are an important component of the system. However, we cannot agree with the Report's suggestion that the CAT definition be changed at this time. The new definition, that was just recently enacted, and is only now beginning to be employed. After a long and extensive review by an expert panel and subsequent consultation process, a new definition has just come into force. Given the need for "permanence," some of these new definitions will not be fully applied for the first time until June of 2018. These new definitions provide greater specificity and clarity and *will result in more efficient determinations and less dispute.*

The Report also proposes that Guides 6 be used to determine the CAT rating, and that the government would take over care of patients with catastrophic impairments. After significant consideration, the Expert Panel reviewing the CAT criteria rejected Guides 6 as less reliable and valid than Guides 4. The government retained Guides 4 following the consultation process. In addition, other more detailed criteria were implemented. Also, while providing lifetime care is an appealing aspiration, the recommendation to turn the provision of the services over to the Ministry of Health and Long Term care removes direction and control from the injured person and their treating health professionals without providing increased funding or resources.

The report suggests changes to the CAT definition without adequate study of this highly complex issue, and without allowing time for an analysis of the impact of new CAT definitions that were only recently enacted. This rush to judgment is not founded or supportable.

- *Retain the use of AMA Guides 4 and other current CAT definitions;*
- *Retain the process that allows the person with CAT impairment and their treating health professional(s) to direct their own health care services.*

### **SOLUTION # 36: Allow injured persons to rely on psychologists to certify CAT impairments due to mental and behaviour disorders.**

The AMA Guides recommend a comprehensive method to determine impairments due to mental and behavioural disorders that follows the psychological method for assessment. Psychologists are also recognized as experts in this area in court and other tribunals.

Relying on the sound, comprehensive psychological method outlined in the 4<sup>th</sup> edition of the AMA Guides and referenced in the current and new CAT definitions improves credibility and trustworthiness, and usefulness of CAT determination assessments to resolve any disputes over CAT status.

It should suffice for a psychologist to certify CAT due to mental and behavioural disorders without the additional involvement of a physician. The requirement that a physician certify the catastrophic impairment applications for injured individuals with mental and behavioral disorders simply adds needless costs to the system.

## **Section 4: Issues regarding legal representation and legal fees and Tort**

### **SOLUTION # 37: Reducing need for legal representation.**

We agree with the Report's goals for a system with less dispute that would create less need for injured persons to require assistance for legal counsel. Development of a System Navigator, simplified materials and more consumer friendly forms will reduce the need for legal assistance. Similarly, reduced disputes will reduce the felt need for an advocate. It is our experience that injured people generally tend to obtain legal counsel when there is a dispute with their insurer.

### **SOLUTION # 38: Allow legal fees arrangements that protect access to legal representation.**

We expect that others more directly involved in this area will comment on the issues regarding legal fees. We also understand that it may be addressed by the relevant legal professional bodies. The solutions proposed in this document to improve trust and reduce disputes will reduce the frequency of the need to rely on legal representation. Consumer protection requires that when the insured person determines that they need legal advice they are able to obtain it. Any controls on the payment arrangements should not interfere with the ability to obtain expert legal advice. This issue can be better addressed by other bodies.

## **SOLUTION # 39: *Rely on the trier of fact to weigh expert opinions***

We agree with the Reports goals of improving the quality and acceptance of examination reports. However, we cannot support the Report recommendations that IE opinions be binding opinions and given a “zone of deference.” It is simply not the case there is a level of precision in expert opinions such that they need not and will not be disputed.

The courts have determined that expert opinion must be judged by the court and cannot stand alone. Opinions are also not trusted when the patient has no chance for input from their chosen treatment provider. Paradoxically, accepting that the IE opinion may and will be challenged in some situations, in fact increases trustworthiness and reduces dispute.

## **Section 5: Role of the regulator**

We note that the report recommends simplification of the legislation and regulations and leaving details to the discretion of the regulator. It is unclear what would be the implications and risk of this recommendation. While this sounds appealing to increase efficiency and flexibility, we would like to see further analysis regarding any risks to consumer protection.

We also believe that the effectiveness of the regulator would be enhanced by including in its governing body stakeholders from all sectors including injured individuals and health professionals.

## **CONCLUSIONS**

In this joint submission, the Ontario Psychological Association (OPA) and Canadian Academy of Psychological Disability Assessors (CAPDA) have addressed important issues raised in the report of the review of the auto insurance system (Report): trustworthiness, disputes, and costs in the auto insurance system. We agree with the Report’s objective to increase access to care for injured persons and to reduce the percentage of funds spent on costs that do not provide services to foster recovery such as Insurer Examinations (IEs).

In this submission we have presented 39 solutions. It is not possible to fully outline all of the details of the proposed solutions. Some also require further development and stakeholder input for implementation.

We would very much appreciate further opportunity to participate in these processes.

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## APPENDIX

### Appendix 1

The following data report is from the Ontario Health Claims Database (HCDB) Standard Report, 2016 – H2, published by the Insurance Bureau of Canada.

#### Percentage Distribution of Expense Class by Medical and Rehabilitation Expense Range and Accident Date

Based on claim transactions between the Accident Date and December 31, 2016

All Claimants - Total				Accident Dates January 1 - June 30, 2012			
Size of Loss Range	Treatment	Insurer Initiated Exam	Provider Initiated Exam	Goods and Supplies	Missed/Cancelled Appoint	Transportation	Others
\$0	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$0+ to \$2,200	66.0%	28.7%	1.7%	0.5%	2.5%	0.5%	0.2%
\$2,200+ to \$3,500	67.9%	26.9%	2.2%	0.8%	1.8%	0.3%	0.2%
\$3,500+ to \$50,000	47.7%	33.9%	9.6%	1.4%	3.9%	2.8%	0.6%
\$50,000+	62.1%	9.6%	5.5%	3.3%	0.7%	18.0%	0.7%

Claimants - Total				Accident Dates July 1 - December 31, 2012			
Size of Loss Range	Treatment	Insurer Initiated Exam	Provider Initiated Exam	Goods and Supplies	Missed/Cancelled Appoint	Transportation	Others
\$0	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$0+ to \$2,200	67.6%	27.5%	1.6%	0.2%	2.5%	0.5%	0.2%
\$2,200+ to \$3,500	67.3%	27.6%	2.2%	0.5%	1.9%	0.3%	0.1%
\$3,500+ to \$50,000	48.7%	33.2%	9.2%	1.6%	3.6%	3.0%	0.6%
\$50,000+	62.1%	9.1%	5.0%	4.1%	0.5%	18.4%	0.8%

## Appendix 2

### Solutions

- SOLUTION # 1: Maintain the current, recently reduced, levels of no-fault benefits
- SOLUTION # 2: Focus further cost saving efforts on non- Accident Benefit costs
- SOLUTION # 3: Include more complete data regarding costs of care and other accident benefits in the Health Claims for Auto Insurance (HCAI) Database.
- SOLUTION # 4: Create an impartial body to develop materials and processes to better educate consumers, insurers, and health professionals
- SOLUTION # 5: Provide specific education regarding the reality of psychological disorders and the role of robust psychological assessments to accurately determine diagnosis.
- SOLUTION # 6: Improve/modernize administrative procedures and forms.
- SOLUTION # 7: Require use of a standard format for reporting treatment outcome.
- SOLUTION # 8: Include the insured person’s electronic signature on treatment plans submitted to HCAI.
- SOLUTION # 9: Include “attachments”, for example, supporting documents and referral notes, on treatment plans submitted to HCAI.
- SOLUTION # 10: Create a “System Navigator” or “Office of Driver Adviser”.
- SOLUTION # 12: Allow all insured persons access to initial funding for care without being subject to insurer denial or IE. Eliminate insurer denials and IEs for all care applications under a pre-determined dollar threshold and initial time period. (dollar value and time period to be determined).
- SOLUTION # 13: Update the current MIG Guideline and/or develop POCs for those with minor injuries/CTIs.
- SOLUTION # 14: Increase or remove the minor injury funding cap.
- SOLUTION # 15: Introduce explicit criteria for routine insurer approval of funding for treatment planning assessment without requiring an IE for injured individuals with non MIG/non CTI injuries.
- SOLUTION # 17: Include case management as a potentially available accident benefit for all injured individuals. Remove the restriction of case management to those who have been determined to have a catastrophic impairment.
- SOLUTION # 18: Require health professionals to confirm that treatment plans are consistent with standards of practice and treatment guidelines.
- SOLUTION # 19: Improve the mandatory report of paid expenses by making it more frequent and informative.
- SOLUTION # 20: Implement the Provider ID tracker to increase trustworthiness, and reduce costs associated with professional identity fraud.
- SOLUTION # 21: Expand the use of the FSCO licensing of all health facilities to address concerns regarding outlier behaviour
- SOLUTION # 22: Ensure that Fee Schedules for SABS Benefits are sufficient to maintain a sufficient supply of health professionals to treat injured individuals.

- SOLUTION # 23: Determine if there is a mechanism to better facilitate return to work.
- SOLUTION # 24: Retain cash settlements of Accident Benefits.
- Solution # 25: Provide ongoing evaluation and resourcing to ensure that the LAT achieves its mandate to resolve disputes about care in a more efficient and timely manner.
- SOLUTION # 26: Create an enforcement mechanism that incorporates the LAT requirement for experts to provide opinion evidence that is “fair, objective, and non-partisan”.
- SOLUTION # 27: The insurer shall offer the insured person five IE examiners/facilities from which the insured person will select one.
- SOLUTION # 28: Require all IE examiners meet standard assessor qualifications.
- SOLUTION # 29: Require that all IE assessments follow standardized assessment processes.
- SOLUTION # 30: Retain the model that allows IEs be delivered by private community-based facilities, large IE companies, or by hospital-based facilities (i.e, Do not require IEs to be hospital-based or centralized).
- SOLUTION # 31: Allow an IE only when the insurer has a reason to question an application from the insured persons health professional(s) ( i.e., Do not make IEs “pre-emptive”).
- SOLUTION # 32: Provide opportunity for the insured person to obtain opinion from their health professional(s) if they disagree with an IE. Do not make IEs “binding”.
- SOLUTION # 33: Utilize “peer review” and consultation between health professional peers to address differences of opinion to improve quality and efficiency of IEs regarding care.
- SOLUTION # 34: Faciliate a more collaborative process to address differences between the treating health professional and the IE examiner prior to proceeding to dispute regarding care.
- SOLUTION # 35: Do not change the CAT definitions.
- SOLUTION # 36: Allow injured persons to rely on psychologists to certify CAT impairments due to mental and behaviour disorders.
- SOLUTION # 37: Reducing need for legal representation.
- SOLUTION # 38: Allow legal fees arrangements that protect access to legal representation.
- SOLUTION # 39: Rely on the trier of fact to weigh expert opinions