



Alliance of Rehabilitation Centres of Ontario (ARCO)

Access to Health Care: Impartial Assessments in the Auto Insurance System

A Response to FSCO's Proposed Assessment
Model to Replace the Disability Assessment Centres-
Draft amendments to O. Regulation 403/96
under the Insurance Act.

January 13, 2005

The Alliance of Rehabilitation Centres of Ontario (ARCO) is a non-profit trade organization representing most of the multidisciplinary rehabilitation providers in Ontario.

ARCO exists to promote best practices in the field of interdisciplinary program-based rehabilitation.

ARCO's members:

- **Operate over 160 multidisciplinary rehabilitation clinics (including DAC's).**
- **Provide independent evaluations to insurers and so are familiar with the assessment system from all perspectives.**
- **Have thousands of hours of experience in the fields of treatment, rehabilitation and assessment of injured motorists.**
- **Many members are participants and have treated claimants within the Ontario Whiplash Project.¹**

¹ The Insurance Bureau of Canada has sponsored the Ontario Whiplash Project currently in effect in the Brampton and Mississauga areas and has been supported by six of its member insurance companies. Representatives from ARCO have also participated. This project is additionally being monitored by the Financial Services Commission of Ontario (FSCO). Preliminary results show a positive effect in reducing duration of treatment. This model incorporates best practices for treating soft tissue injuries with continuum of care elements. This model includes medical management, acute/sub acute treatment (essentially PAF) for up to six weeks at which point, if there are ongoing limitations, a multidisciplinary evaluation is carried out and recommendations are made as to progression to an interdisciplinary rehabilitation stream or if specialist intervention is required.

I. INTRODUCTION

At the outset, we want to put on record that there are a number of positive aspects to the draft regulations proposed by the government. In our document, while we will be making a number of recommendations that we believe will strengthen Ontario's automobile insurance system, we will also be underlining areas in which we agree with the direction the government is taking. Our document format provides an overview of the government's proposed changes and then focuses on three important issues. An Appendix is also provided to explain more fully our recommendations regarding a more neutral and impartial assessment model.

II. OVERVIEW

When an injured person makes a claim against his or her insurer for personal injuries caused by a motor vehicle accident, there is a natural tension between the desire of the injured person to substantiate his or her complaints and the desire of the insurer to prove that damage is minimal or non-existent. Typically, the claimant obtains a medical report from his or her family doctor enumerating the injuries and stating that the patient could not return to pre-injury function for various reasons. The insurer would respond by producing its own medical examination that minimized the injuries stemming from the accident and state that the person was not disabled by the accident.

In 1994, a system of Disability Assessment Centres (DACs) was introduced in an effort to introduce accountability to the required assessments and attempt to build a foundation for an impartial assessment system. However, the DAC system suffers from

certain inherent flaws that the current proposed regulations will address. ARCO endorses a single assessment system (as the regulations propose) that is designed to streamline the assessment process. Allowing insurers to purchase services from a wide range of providers means that market forces will come to bear and the cost of assessments and the service delivery involved in those assessments will improve. This will have the salutary effect of reducing the amount of time and resources that are spent on the assessment process, thereby potentially increasing the time and resources to be devoted to the treatment and rehabilitation of those injured in motor vehicle accidents, resulting in lower costs for all consumers.

The current proposed regulations will improve timelines and reduce costs for assessments but they suffer from a lack of attention to the pervasive problems of neutrality and impartiality. A “one-sided” system will benefit no one since poorly managed injuries will only add future costs to the motor vehicle insurance system and to our social structure (e.g. Medicare) as a whole. For example, up to 80% of lost time injuries in motor vehicle accidents are soft tissue in nature, i.e. strains and sprains². It is common knowledge that these cases are among the most difficult to manage and assess due to the frequent subjective nature of the injuries and complaints. They can further develop into chronic pain disorders and related disabilities and become very costly in terms of insurance benefits paid out. Management of these claimants means that they must receive just the right amount of rehabilitation – not too much, not too little – and in a timely fashion, so that they can return to pre-injury function. The goal of our

² There are approximately 60,000 lost work time personal injuries in Ontario motor vehicle accidents per year.

assessment system in Ontario should result in a treatment recommendation that allows for the right treatment at the right time.

Because many motor vehicle injuries are difficult to assess, they are easily subject to selective assessment techniques and biased opinion. In other words, it is quite possible to defend a view that the patient is, on one extreme, completely disabled from their complaints or, on the other extreme, completely fabricating their complaints. This dichotomy creates mistrust, increases the adversarial nature of claims and creates issues of legitimacy that encourage disability behaviour and health care utilization on the part of the insured person in order to “prove” that something is wrong. Research has demonstrated this to be a significant factor in ongoing disability along with excessive exposure to assessments focused on “disproving” the individual's complaints. “You cannot get better if you must prove you are ill.” (Dr. Nortin Hadler).

Professional Colleges cannot resolve this dichotomy. This problem is not within the scope of their mandate. They set qualifications for entry into the profession and take steps to protect the public from malpractice and unethical behaviour. The issue here is not professional competence or professional malpractice. It has to do with providing assessments that have guiding principles compatible with the principles outlined in the decisions made by FSCO arbitrators.

As clear objective data may be lacking in some cases, concern has at times been raised regarding the validity of such claims. Recent evidence from functional MRI's, PET scans etc point to changes within the central nervous system that confirm biological changes consistent with the subjective symptoms of these patients. The Supreme Court

of Canada also recently considered the validity of chronic pain disabilities. In a landmark decision (*Martin vs. WCBNS*) the court determined that these cases are valid and cannot be discriminated against solely on the basis of the category of claim and on the expectation that this class of claims “should” get better.

Under the government’s proposed regulations, once an assessor has made a finding that a claimant is not disabled and does not require treatment, the recourse available to the legitimately injured person will be the slow and uncertain legal process of mediation and arbitration. Together, these processes can take up to two years to complete. Yet scientific evidence shows that these cases are most successfully treated at the sub-acute and early chronic phase – between 4 and 16 weeks – and that most chronic soft-tissue problems can be prevented if addressed early. The proposed assessment model will quite clearly delay access to appropriate care beyond the recommended time frames for treatment. This is an instance where rehabilitation delayed amounts to rehabilitation denied.

When no fault was strengthened in 1990, there was a classic trade off in that access to tort was limited at the same time. The basic principle of no fault allows individuals wage replacement benefits and access to health care to assist them in the recovery process. This is an area in which tort is particularly weak because benefits are not available until the case is finally settled, or until there is a judgment. Therefore one of the driving principles of no fault is the goal of “timely recovery”.

The proposed regulations appear to be 'blind' to this basic principle of no-fault. For example, if a legitimately injured person is denied access to necessary treatment based solely on an assessment and report commissioned by their insurer, their only recourse is to go through a lengthy mediation and arbitration process. There may be a significant recovery for claimants at that time, but the access to timely recovery has been lost. In addition, the cost of recovery will be far greater due to the chronicity of the problem. There is only a certain window of opportunity for appropriate health care. In this way, the current proposed regulations simply superimpose a tort mechanism on top of a no fault system without providing the benefit of early intervention that no fault was intended to give.

A process that effectively denies treatment to insured persons until the point where they can no longer benefit from treatment is one that no one wants. It benefits no one, not insurers, not injured persons and not our province as a whole. These claimants will fail to recover, will be unable to return to their jobs, will make larger claims for income loss to tort carriers, will become a burden on their employers and their insurance plans (Long Term Disability and Extended Health Benefits) and will become heavy users of our publicly funded health care system.³ If claimants settle their claims without proper treatment, then the costs of their injuries are effectively passed on to the provincial Medicare system. The potential of legitimately injured individuals to live active, productive lives will be squandered due to no fault of their own.

³ **Blyth FM.** Chronic pain and frequent use of health care. (*Pain*. 111 2004 51-58), **Gerdle B.** Prevalence of chronic pain and its influence upon work and healthcare-seeking. (*J Rheumatol*. 2004 Jul; 31(7): 1399-1406), **Andersson HI.** Impact of chronic pain on health care seeking, self-care, and medication. (*J Epidemiol Community Health*. 1999 53(8): 503-9.)

III. TOWARDS A NEUTRAL, IMPARTIAL ASSESSMENT MODEL

It is in the best interests of all stakeholders concerned to ensure that assessments and assessors are as neutral and impartial as possible without undue additional bureaucracy. Assessors must evaluate each case on its individual merits as pointed out by the Supreme Court of Canada.

To ensure neutral and impartial assessments while retaining a market driven system requires four basic steps.

ARCO Recommends:

- 1. Maintain a qualified assessment roster listing approved assessors.**
- 2. Require all assessors to undergo annual training.**
- 3. Develop an audit system to improve quality.**
- 4. Provide for accreditation of facilities delivering independent assessment services.**

We are proposing a roster that is as broad and inclusive as possible but has the increasing obligation of yearly training and adoption of the principles outlined in arbitration decisions in determining treatment and disability recommendations. In our opinion, a system such as this, with an audit component to ensure compliance, will quickly lead to the impartial, high-quality assessment model we would all like to achieve without compromising cost effectiveness or service delivery timelines. These features

are more fully outlined in Appendix I (attached) and we would agree that there is much room for variation in detail.⁴

ARCO recognizes that the current referral system does not always work well. We believe it is in the interest of all in the sector to try to create a more effective system and are prepared to collaborate with everyone to achieve that goal.

IV. PAPER REVIEWS: “REASONABLE AND NECESSARY” VS. “REASONABLY REQUIRED”

The “Fast-Track DAC’s” were introduced in the fall of 2003 to improve the speed of decision making when a health care provider was proposing an assessment for preparation of a Treatment Plan or recommending treatment outside of the PAF (Pre-Approved Framework). Because the assessor in this instance would not actually be making direct contact with the claimant and would rely solely on previously prepared assessments, the DAC Manual provided for a less restrictive test for this type of assessment. Specifically, the DAC Rehab Manual (August 2003) states “The purpose of the Fast-Track DAC is to offer an opinion about: ...the test of being reasonable fees charged by a member of a health profession for conducting an assessment or examination in preparing a report, where the assessment or examination and the report are *reasonably required* in connection with the benefit claimed or the preparation of a Treatment Plan...” (italics added).

⁴ Many of these features have also been proposed by the Insurance Bureau of Canada (see Timely, Authoritative, Cost-Effective Assessments in the Auto Insurance System, April 2004).

This test “reasonably required” is distinct from that outlined in the draft regulations, that being “reasonable and necessary”. “Reasonably required” allows more leeway for the assessor, as they are not actually seeing the claimant but rather relying on previous reports. In our opinion, the government's proposed change increases the chances that a legitimately disabled person will be ignored and prevented from receiving needed care. In our view, to use the test “reasonable and necessary” for a Paper Review places legitimately injured persons in jeopardy of not receiving needed care in the appropriate time frame. We would like to point out that the recommendations in the draft regulations are that disputes of this nature will be forwarded to mediation (which will take at least 60 days) and then, if needed, to arbitration which, in past experience, can take two years or more. This means that it would not be unexpected for an individual to be denied an assessment and then not properly assessed for more than two years when the issue is resolved at arbitration. In our opinion, this is an unacceptable outcome, which will result in much greater levels of disability and suffering.

ARCO Recommends:

- **the current test for a Paper Review be retained.**

V. PRE-CLAIM EXAMINATION

Another issue of concern to ARCO is the proposal in the draft regulations to establish a pre-claim examination process. ARCO is concerned that these assessments may create an adversarial tone from the outset. Furthermore, there should be no section 42 examinations other than for PAF ancillary goods and services if the claimant is treated under a PAF. The first insurer examination should take place if the claimant is not

treated under a PAF or should the claimant require treatment beyond the PAF. The assessment could be a fairly standard one with a clinician, physiotherapist or chiropractor, and a physician with expertise with soft tissue type injuries. This type of assessment model would be fairly easy to put in place in the marketplace.

ARCO Recommends:

- **the pre-claim examination process as outlined in the proposed regulations be removed.**
- **limited Section 42 assessments while a claimant is undergoing treatment in a PAF.**

APPENDIX I

To ensure neutral and impartial assessments while retaining a market driven system requires four basic steps.

ARCO Recommends:

1. **Maintain a qualified assessment roster listing approved assessors.**
2. **Require all assessors to undergo annual training.**
3. **Develop an audit system/committee to improve quality.**
4. **Provide for accreditation of facilities delivering independent assessment services.**

1. Assessment Roster

A Roster is simply a list of approved assessors, which would be maintained by FSCO, or a designated organization appointed by FSCO. Only rostered assessors will be permitted to assess under Sections 42, 24 and the proposed pre-claim assessments. It will comprise registered health care practitioners and vocational rehabilitation consultants and will be open to all of the above who meet the following criteria:

- a. minimum of three years in practice.
- b. an ongoing balanced practice – meaning that the practitioner provides both assessment and treatment on an ongoing basis for similar cases.
- c. can assess patients falling under one or more of the following Areas of Expertise:

- soft tissue injuries
- musculoskeletal disorders
- chronic pain
- psychotraumatic injuries
- brain injuries
- dental/jaw injuries
- catastrophic injuries
- vocational impairments
- spinal cord injuries
- burns
- neurological impairments.

An assessor will submit to FSCO (or its designate), proof of registration in good standing, proof of years in practice and a statement that they have a balanced practice. They will also identify the Areas of Expertise they feel they are suitably qualified to assess. This information will be available to insurers and the public on a website maintained by FSCO or its designate. At any time the assessor can request that their Areas of Expertise be changed or they may withdraw voluntarily from the roster. Insurers may only choose a health care practitioner or vocational rehabilitation consultants who are listed on the roster in good standing. However, it is intended that the list will be as broad and inclusive as possible so the largest possible pool of assessors are available in all parts of Ontario.

2. Annual Training

We propose that each assessor on the Roster, in order to remain in good standing, undergo a minimum of eight hours of training per year. The training will be provided by

FSCO or by a designate. Training could take place on a single day or be spread throughout the year. The training should include basic process information and report writing information, answering questions, such as: *What is the best way to conduct this assessment? How do we apply the SABS in this instance? How does one explain the rationale for a decision and opinion?* In addition key content information will be provided, such as: *What does the scientific literature say about managing this kind of problem? What have the arbitration decisions been on this particular issue?*

These training courses would be offered in various centers throughout Ontario on a periodic basis.

We would like to point out that basic and ongoing training requirements for assessors is a common feature found in many disability systems and jurisdictions e.g. WSIB, Professional Colleges. To have the ongoing privilege of being an assessor there is an obligation of remaining current and being well trained in a chosen field.

3. Audit Committee

In the pressure to produce lower cost and timely assessments, we do not want to miss the point that the assessments must be accurate, based on current knowledge, well stated and clearly reasoned. They must be fair both to the insurer as the funding body and also to the injured accident victim (who has the most to lose or gain by the impact of that decision). In order to improve the quality of the work being done, we propose that an Audit Committee be formed which would comprise stakeholders such as health

care professionals, insurers, government appointees and representatives from consumer associations.

The roles and duties of the Audit Committee would be as follows:

1. Appoint designates to approve new applicants to the Assessment Roster using the criteria outlined above.
2. Set standards for report quality and consistency.
3. Provide a random monitoring system to review the quality and consistency of assessors' reports.
4. Review arbitration decisions and determine if they support or reject the opinion of the assessor.

Potential Sanctions Imposed by the Audit Committee

The Audit Committee will have a role in reviewing both the process as well as content of assessments. The available sanctions should include the following options:

- A. Written warning to an assessor about either the process or content of a report.
- B. Requirement that an assessor take additional training in a subject area such as report preparation or in one of the Areas of Expertise identified by that assessor.
- C. Removal of an Area of Expertise from a rostered assessor.
- D. Removal of an assessor from the Roster. It is recommended that a step of this nature be taken only in the following instances:

- where there are repeated infractions and/or warnings.
- failure to undertake the annual training requirements.
- where there are a minimum of three arbitration decisions that rule contrary to the assessor's opinion.⁵

4. Accreditation of facilities delivering independent assessment services

Systems that impose minimal standards and sanctions can set the *floor* for the quality of assessments provided to insured persons and payors within the auto insurance system. A system of accreditation would help to raise the *ceiling* of quality within the system by encouraging providers to monitor outcomes and customer satisfaction and strive to continually improve the efficiency and effectiveness of service. The new system should adopt a system of accreditation that will ensure that providers are taking action to monitor and improve the quality of service on an ongoing basis. This system should include minimal standards of human resource management, physical plant, process and outcome evaluation, and continuous improvement. This system could utilize existing accreditation protocols for a basis and would be administered by a neutral third party. A system of accreditation not only creates standards for organizations and individuals but shapes behaviour in a fashion that maintains a focus on value.

⁵ Arbitration decisions are the ultimate test of the validity and veracity of an assessor's opinion. If the assessor fails to look at the range of issues that an arbitrator deems important they will not provide an assessment that will contribute to the successful resolution of a case. For this reason, we propose that they will form the basis of some of the more powerful sanctions wielded by the Audit Committee.