

This level of complexity places a great burden on both patients and providers as they struggle to understand and work effectively within this system.

The Ontario Claims Forms are an excellent illustration of unnecessary administrative complexity. Simply initiating a claim with an insurer is difficult. The Coalition survey asked if providers were habitually helping patients to complete their applications and if treatment or assessment was ever delayed as a result of the AB package not being completed:

“According to the results, 19% of respondents are “Always” asked to help a patient complete their AB packages, with 43% “Sometimes” getting this request. 39% are asked either “Rarely” or “Never”. Combined with the data that 11% of patients have a delay in treatment or assessment because of incomplete applications (with 61% “sometimes” experiencing this), the complexity of the applications seem to be putting both an undue burden on some healthcare providers while also acting as a barrier to timely intervention.”¹

While OPA fully recognizes and supports the need for accurate and usable data pertaining to the use and cost of services in the auto sector, we feel it is important to ask: "What information does the insurer really require in order to adjudicate a claim?" Is it important, for example, that the insurer be able to distinguish on a treatment plan the amount of time devoted to ultrasound versus hydrotherapy? All forms need to reflect data that is reasonably required, rather than simply “nice to know”.

OPA recommends a complete review of all OCF forms and applications processes, including the coding mechanisms, with a view towards simplification of data requirements and in turn data accuracy. We must also take into serious consideration the cost to insurers and providers in implementing ANY changes to claims forms, particularly in light of the HCAI project and various practice management packages that incorporate these forms.

Co-ordination of Benefits

Legislation currently requires that all invoices for healthcare services must be first submitted to any other available insurance plan prior to consideration by the auto insurer. While the patient is ultimately responsible for the co-ordination of their benefits coverage, it often falls to the health care provider to submit invoices and forward explanations of benefits on behalf of the patient.

For providers, this is one of the most contentious issues in auto insurance.

According to the survey results, half of all respondents indicated that between 25% and 74% of their patients had access to other health insurance coverage. Only 21% of respondents agreed

¹ Auto Insurance Regulations Review Survey Results, 2008, p.2.

that their experience in receiving payment from EHB before billing the auto insurer was satisfactory, with 48% indicating dissatisfaction.

While the OCF-21 standard invoice allows for the provider to report payment from other insurers, many auto insurers also require the submission of an Explanation of Benefits as proof that additional coverage was either accessed or unavailable. In fact, 58% of those surveyed indicated that insurers “always” require documentation from the EHB insurer prior to paying for services, this despite there being no such requirements in the SABS.

In addition to being viewed as generally unfair this has a huge impact on access to needed health services outside of injuries related to automobile accidents, in that it forces people with extended health benefits plans (through their employer or purchased privately) to use their coverage in cases of automobile accidents (for which they are legally obligated to purchase additional coverage), it also imposes an increased administrative burden on providers. Difficulties are reported in getting information from patients or their EHB insurers, leading to delays in payment and increased transaction costs. These transaction costs create an undue financial burden on providers who must absorb them.

When survey respondents were asked how co-ordination of benefits could be facilitated through changes to statute or regulation, there were many common themes expressed including changing the *Insurance Act* to remove the “last payor” provision and having the MVA insurer assume the responsibility of co-ordinating other benefits and recouping any monies owed to them.

Recommendation: OPA agrees with the recommendation of the Coalition that stakeholders should be consulted on simplifying or amending the process for co-ordination of benefits. In addition, we recommend that such consultation be initiated immediately.

Fees

The Ontario Physiotherapy MVA Fee Guideline of \$95-120 per hour for physiotherapy services was negotiated and agreed with the industry in good faith and endorsed by the government in 1996. It remained unchanged for seven years until the Professional Services Guideline was introduced in October 2003 when physiotherapy fees were unilaterally cut by 30% (for some other professions, cuts were as high as 50%). In the subsequent years, FSCO has raised the physiotherapy fee by an average of 2% per year (i.e. lower than the rate of inflation) and the MVA fee now sits at roughly 61% of the OPA recommended fee guideline of \$37.50 per fifteen-minute unit.

The administrative burden imposed on health care practitioners who provide services to auto insurance claimants is onerous. No other sector requires the level of oversight by non-health

professionals, the submission of complex forms, report writing, legal intervention and the intensity of interaction with the payor.

OPA recommends a review of the Professional Services Guideline and a return to fees that are more in line with the Association fee guidelines for health care services in Ontario.

We trust that the above comments will assist FSCO with their current review. Please contact us with any comments or questions.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Sauvé". The signature is fluid and cursive, with a prominent initial "D" and a stylized "Sauvé".

Dorianne Sauvé
Chief Executive Officer