

February 8, 2019

The Hon. Victor Fedeli

Minster of Finance

c/o Budget Secretariat

Frost Building North, 3rd Floor

95 Grosvenor Street

Toronto, Ontario

M7A 1Z1

Dear Minister Fedeli,

**Re: Pre‐Budget Submission to the Minister of Finance**

HVE Healthcare Assessments Incorporated (“HVE”) was founded in 1994 and is an industry leading provider of independent medical assessments (“IMEs”). We are a privately owned and operated Canadian company; holding both national and internationally recognized accreditations. We employ 75 Ontarians and utilize a vetted roster of more than 600 health care professionals to accept, review, assess and report on 33,000 service requests annually on behalf of Ontario’s auto insurance companies. Additionally, we provide independent healthcare services to both private and public sector organizations.

At the outset, we are pleased to submit several recommendations focused on lowering costs in the system while ensuring that injured claimants receive the treatment, they need so that they can return to pre-collision health. HVE is an ISO 9001:2015 and CARF IES accredited company. CARF is the acronym for the Commission on Accreditation of Rehabilitation Facilities, an international and independent, non-profit accreditor of health and human services. Continuous improvement is at the core of our organization. With this in mind, we believe that system wide efficiencies and cost reductions can be achieved by taking into consideration the following recommendations.

**1. Claimant non-compliance controls should be put in place**

We understand that the previous Liberal government reduced benefits as a means of attempting to control and reduce costs in the Accident Benefits system. While we do not wish to further impact injured claimants by penalizing them for not complying with the requirements for undergoing IMEs, we nevertheless believe that reasonable requirements for attendance at such examinations should be enforced, both as a means of ensuring quicker access to treatment and of lowering costs in the system.

The data shows the following costs for “no shows” and late cancellations for insurer IMEs:

* + 25% of all scheduled medical assessments are cancelled and rescheduled by claimants and their legal representatives for no valid reason.
  + 18% of all assessments are “no shows” or claimant late cancellations (i.e. cancelling assessments within 48 hours of the appointment date).
  + 8% of all IME costs can be attributed to claimant no shows and late cancellations.
  + No shows and late cancellations delay access to assessments for claimants who require a timely, neutral, independent and objective medical opinion.
  + No shows and late cancellations delay needed treatment, lengthen unnecessary treatment which may unnecessarily increase claims costs such as medical rehabilitation and income replacement costs.
  + No shows and late cancellations remove valuable time from assessing physicians that block book assessment time in their calendars for the provision of assessments. This time is time lost to the greater health system in Ontario.

Previous versions of the Statutory Accident Benefits Schedule (“**SABS**”) prohibited claimants from receiving ongoing disability benefits during the period of non-compliance. Similarly, previous versions prevented claimants from receiving treatment if they did not attend an insurer required IME. There is no equivalent in the current versions of the SABS.

From our company’s experience, an 8% cost savings would result from reducing these late cancellations and “no shows” by putting in place stricter penalties or restrictions for “no shows” and late cancels.

**2. Standardization of protocols, documents and reports is required**

The lack of consistency amongst insurers in terms of the IME process adds unnecessary administrative and professional costs to the system as a whole. The lack of standardization within the IME process leaves room for substantial differences between insurers, and between first party and third-party medical examination reports. The following are examples of inefficiencies which could be addressed with standardization:

* There is a large variance between insurers in respect of the method of file submission, the type and number of questions, reporting requirements, reporting timelines and costs.
* Some insurers have established a standard set of questions for assessors, while others have not.
* Some insurers submit a small set of questions to an IME assessor while others will ask up to 25 questions to address a single Treatment Plan.
* Non-standardized consent forms have led to an increase in late cancellations and “no- show” costs. Claimants and legal representatives request changes to consent forms just prior to, or during, assessments, which, if not resolved, lead to unnecessary incomplete appointments. If the consent form were standardized, these last minute proposed changes would not occur, thereby eliminating any “no-show” or late cancellations that result from these types of requests.

If the following documents and processes were standardized, the cost of the process overall would be reduced:

* Referral forms
* Document lists
* Documentation file formats and organization
* IME questions
* Consent forms

We also recommend the discontinuation of Executive Summaries for Non-CAT referrals. An Executive Summary is a report that summarizes the opinions of the assessors that are involved in the multidisciplinary assessment. There is no net new information offered in an Executive Summary. Some insurers require these to be completed on multidisciplinary assessments. Elimination of these low value reports would help to reduce costs.

With the above standardizations in place, IME companies would be able to negotiate costs based on a standard product that is consistent among all referral sources.

We expect a 5-7% cost reduction if the above recommendations were put in place.

**3. Inconsistent fees between plaintiff and insurer assessors should be levelled**

The fees for accident benefit reports are capped by the SABS at $2,000 for insurer side IME reports. Reports that come close to the fee cap tend to be the exception, rather than the rule. Any perception that reports typically cost $2,000 is simply incorrect. The average cost of a report is between $800 and $1,100. The challenge is that the same cost restrictions do not apply to plaintiff IME reports. The claimant is not prohibited from paying beyond the fee cap in order to access a specialist that is an expert.

Similarly, files that are complex, or involve substantial documentation review and therefore additional time, are not limited by the same cap. As a result, a plaintiff has the ability to access a different set of experts than an insurer IME. The result is increased costs in the system paid by plaintiffs and an adversarial context for IMEs wherein assessors typically only do work on one side of a file, as plaintiff fees are substantially higher because the market, not the regulator, dictates fees.

We recommend reasonable cost of living increases to the fee cap, coupled with an allowance for a fee exception on the insurers side, as appropriate.

**4. The neutrality of assessments should be paramount and controlled**

Apart from cost reductions, we also believe that an essential element of ensuring that injured claimants obtain the treatment they need in order to return to good health and ultimately work, is to ensure that the medical assessments they undergo are provided in a professional, unbiased and neutral manner.

In order to ensure a neutral assessment, HVE requires its professional assessors to be in active practice. We only accept physicians on our roster of assessors who are actually treating injured patients so that they will continually have an appreciation of the types of injuries, both physical and psychological, that are common in motor vehicle accidents, are less likely to discount or disbelieve the narrative provided by those they will be assessing, something that is especially important when dealing with soft tissue injuries that are not readily visible, and be able to call upon that experience in not only assessing injuries but also in recommending treatment for those injuries.

Maintaining an active practice also ensures that these assessors will be required to participate in continuing education as required by their regulatory colleges. This ensures that the assessors remain current in both substantive knowledge and professional issues. In addition, these physicians/health care practitioners will treat MVA victims in their practices. Whether this occurs in a hospital setting, a physician’s office or in a clinic setting, the assessors that are in practice will see MVA patients on a regular basis for treatment. As such, they are making recommendations for these individuals as patients, in a similar manner as they make recommendations in their IME reports.

A great deal of emphasis has been placed on the need for independence in the provision of IME services, a principle that we fully support so that injured claimants are treated fairly and receive the best advice for treatment of their injuries. We understand that there is a perception that IMEs are not in fact independent from the biases of the specialists that conduct the examinations.

HVE places a premium on the concept of independence. In fact, assessors selected to conduct IMEs are compensated by HVE, not insurers. Assessors do not communicate with insurance company adjusters who have carriage of claims. Moreover, HVE defends the assessor and his or her reports in respect of complaints from insurers who disagree with their conclusions.

IME assessors should have no contact with the referral source (i.e. insurer or law firm) to ensure independence. We are an arms length buffer between the referral source and an assessor. This does not occur on the plaintiff side where assessors are hired directly by plaintiff lawyers who have access to their draft reports in a manner the defense side does not as a result of the IME industry.

**5. Accreditation and Licensing**

We believe that IME providers should be subject to specific accreditation standards in order to ensure the highest standards for IME companies. We recommend the following:

* The current FSCO Service Provider Licence should be updated and enhanced to include a separate class for IME companies.
* Annual renewals and compliance audits for the purpose of monitoring FSCO licensing.
* Mandatory CARF (Commission on Accreditation of Rehab Facilities) and ISO Accreditation for the purposes of ensuring claimant management and business processes, respectively, are best in class and audited by a neutral third party.

We are confident that these recommendations will support the objective of reducing costs and assisting injured claimants with their injuries. We would be pleased to continue to work with your FSRA to advance these objectives.

**6. Independent Medical Examinations: Credibility and Standards**

We note the concern expressed by David Marshall in his report on the state of the Ontario auto insurance product wherein he cited Justice Douglas Cunningham in connection with his review of the dispute resolution system in the auto insurance sector. In his final report, Justice Cunningham stated:

“Today’s insurer examination (IE) reports appear to have little credibility with claimants and only service to trigger disputes. … IE assessors are not accountable to FSCO, have no standard assessment protocols, report formats or timelines and are not insulated from outside influence.”

This is an unfortunate conclusion for several reasons. The Marshall Report contains no evidence to support this statement. Had Mr. Marshall interviewed HVE, or any other credible IME company, he might have arrived at a different conclusion.

HVE operates under professional services agreements with insurers that prescribe the services that are required to be performed, but which do not in any way dictate the specific assessment outcomes that are expected by these insurers. That principle should continue and be part of the operating process for all IME companies. As a measure of what our service agreements require, we note the following:

* strict protocols for the method in which the services are to be performed, including but not limited to: how appointments for assessment are to be arranged; the time frames within which the assessments are to be performed; security requirements in respect of the delivery of services, including data, records, etc.; the scheduling of audits to verify the accuracy of invoices, determine compliance with agreements, and evaluate the services.
* strict compliance with all legislation, regulation, by-laws,, including privacy legislation, workers’ compensation law, AODA and applicable standards and occupational health and safety law;
* an obligation to maintain in good standing all rights, licences, permits, registrations and approvals that are necessary to provide the services contracted for;
* the timely performance of the services in a professional and competent manner, and more specifically, using only qualified and competent professionals; implementing and enforcing quality control procedures; and employing facilities that comply with all legislation and regulations;
* the provision of professional services as follows:
* Provide single and multi-disciplinary disability independent medical evaluations to determine the nature and extent of an injury and conducted by a network of accredited and experienced medical specialists;
* Ensure that professionals conducting medical examinations do so in an impartial and objective manner, document the findings in formal written report that addresses specific questions associated with the diagnoses and treatment of the claimant’s injuries; and
* Ensure that each Report is reasonable, fair, balanced, comprehensive and accurate and the following practices are adhered to by the Independent Healthcare Assessor:

1. all documents provided in every Report are listed with sufficient detail;
2. signed consent forms from each Claimant are obtained for each In-Person

Review;

1. identification of each Claimant being evaluated is verified;
2. time spent with Assessor for every In-Person Review is properly recorded;
3. acknowledgement of other evaluators’ reports as part of multi-disciplinary evaluation process;
4. review with the claimant of material provided by insurer (e.g. treatment plan in dispute, etc.); and
5. consistent dating of reports contained within a multi-disciplinary evaluation Report.

* Upon written approval of the insurer, and subject to the Financial Services Commission of Ontario (FSCO) professional services guideline, supply interpreters, chaperones and arrange accommodations and transportation services for claimants;
* Ensure that professionals with the requisite musculoskeletal qualifications review functional abilities evaluations and provide comment as part of the disability evaluation;
* Ensure a customer satisfaction survey is provided to all claimants and respond appropriately to any complaints by claimants concerning the quality of service provided and notify the insurer promptly upon receipt of such complaints;
* Ensure compliance with the strict timeframes for completion of services, and
* Complete a report based on a reporting guideline that includes these and many more reporting factors: type of assessment; SABS benefit addressed; documents in dispute; assessor; date assessed; date of loss; duration of assessment; professional credentials of assessor; purpose of assessment; document list; medical history of claimant; medication; work history; details of motor vehicle accident as reported by claimant and from other sources; examination; recommendations for further treatment or testing; and conclusions/opinion.

Over and above the strict processes set out above, HVE has developed a rigorous quality assurance program to ensure quality independent assessments free from conflicts of interest. HVE’s Quality Assurance Program includes:

* ISO9001:2015 Quality Management Certification;
* CARF IME (adults and children) Accreditation;
* FSCO Service Provider Licensing;
* Full time performance manager to monitor and audit its processes;
* Collection and analyzing insurer, claimant and assessor feedback to continuously focus on service improvement;
* Every referral is subjected to rigorous due diligence as part of its documented processes;
* HVE monitors and measures various aspects of its business and services; it collects data based on feedback from customers, staff and other stakeholders;
* A formal quality management system review is conducted annually;
* A significant investment in personnel, systems and training programs to improve customer service levels and operational efficiencies;
* Clinical coordination of each referral: detailed file review; appropriate health care team member appointment;
* Daily management audit reports which include new referrals, appointments and associated external services such as interpreters, transportation services;
* A Management Information System that supports the Quality Assurance Program and,
* Weekly staff meetings and monthly management reviews to identify quality issues and identify deficiencies and create action plans to remedy such issues.

HVE believes that objectivity and independence are critical components of the services that we provide. Our services should be viewed in light of the steps we have taken to ensure independence and avoidance of conflicts of interest:

1. We are one of the few independent privately owned IME companies of our structure and size.
2. We have no outside investors or stakeholders, lines of business including affiliates, franchises, corporate divisions or any other legal link with entities thereby ensuring that our services do not produce any conflict of interest.
3. HVE pays our evaluators promptly (i.e. monthly), carrying the financial responsibility for each assessment completed until the Insurer settles the account. This strategy firewalls the Insurer from a less reliable evaluator and shows confidence by the organization.

We currently provide Quality Assurance from the receipt of a referral by ensuring insurers are complying with the SABS in respect to their requests for assessments and by ensuring that assessors are providing independent assessments that adhere to the disability tests under examination by the referral source.  We support and train hundreds of insurer claims representatives (i.e. adjusters) along with more than 600 health care professionals each year.  This is a daily activity and a core component of the service that we provide.

HVE employs standard assessment and timing protocols, reporting formats and a rigorous Quality Assurance Program. Moreover, its adherence to a policy of avoiding conflicts of interest and outside influences are a key component of the services it delivers. It is unfortunate that this aspect of the delivery of IME services was not explored as part of Mr. Marshall’s review of the auto insurance product. In our view, formally mandating these types of protocols and programs should considered by FSRA as part of its consideration of the auto insurance product.

**7. Multiple and Competing Assessments**

The issue of multiple assessments of injuries sustained by claimants has not been clearly understood. The need for multiple assessments is not the result of conscious efforts by health care assessment companies to create opportunities to increase the number of assessments. Rather, it is a function of the specific provisions of the current Statutory Accident Benefits Schedule (SABS).

*The SABS provides for a number of benefit categories that are available to claimants, including disability benefits (e.g. income replacement benefits and non-earner benefits), medical, rehabilitation and attendant care benefits. Claimants are entitled to apply for benefits under any of the categories which are applicable to them, based on their status and injury. If a claimant applies for a benefit, he or she must satisfy the test of disability applicable to that benefit. As there is more than one benefit, there is more than one test that can apply to a single individual.*

Moreover, plaintiff lawyers also request assessments in order to produce evidence on behalf of their clients. The SABS recognizes that there are a variety of claimants, demonstrating a variety of injuries and who are in substantially different circumstances and phases of their personal and professional lives. Moreover, by its very nature, different health care needs must be assessed and treated by different providers. A “one-size fits all” approach to assessments with an arbitrary limit on the number of assessments is not a reasonable response to the perception that the number of assessments currently being conducted is excessive. The current structure of the SABS drives assessments on multiple fronts:

1. The benefit must be in dispute.

Section 44 of the SABS provides that, for the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit, the insurer may require a claimant to undergo an Independent Medical Examination (IME). In other words, the issue of eligibility for a benefit must be in dispute. If the benefit is not in dispute, the insurer cannot address it by requiring an IME. It must be remembered that every instance where an insurer receives a new a claim, whether for treatment, medical devices, assessments, or benefits, the potential for a dispute exists. The insurer can either pay the benefit/medical expenses submitted, or dispute this and recommend a second opinion by way of an assessment.

Under the SABS, the insurer, does not have the right to require a claimant to undergo an assessment and ask for an opinion on a benefit that the claimant has not yet claimed. For example, if the claimant has not pursued attendant care, he or she cannot be required to undergo an assessment until such time that the eligibility for the benefit is actually in dispute.

2. Multiple benefit types are available under the SABS.

Benefits available under the SABS include medical and rehabilitation, income benefits, non- earner benefits, attendant care benefits, etc. The assessor that addresses entitlement to attendant care benefits (OT/RN) would not be the assessor that addresses a claimant’s ability to perform their employment (FAE/Physician). Similarly, a claimant that requires a major housing modification would not be properly assessed by a physician if another assessor and contractor had not first attended the residence to determine whether the requested modifications are reasonable and necessary.

3. The SABS specifies the assessors required for particular benefit types.

Certain benefit types can only be addressed by specified assessors in response in accordance with the provisions of the SABS. For example, only an occupational therapist or a registered nurse can address attendant care needs. Only a physician or neuropsychologist can assess traumatic brain injury in relation to a catastrophic impairment (CAT) benefit claim. While these specialists can address these particular injuries and benefit types, they are not able to address other claims for benefits that are being advanced.

4. CAT Assessments require multiple assessors.

A CAT assessment involves a determination made in accordance with the AMA Guides. Each chapter of the Guides focuses on a different system (i.e. Chapter 3 deals with musculoskeletal, Chapter 4 is Neurological, Chapter 5 is Respiratory System). A CAT determination in accordance with the SABS cannot be undertaken without examinations conducted by multiple specialists.

We do not believe that a single assessment, conducted early in the claim process, can address all potential entitlements under the current version of the SABS.

Finally, it is important to note that health care assessment companies do possess an expertise in clinical opinions or assessments of patients’ injuries. Clearly, that expertise rests with health care and medical specialists. However, companies like HVE are experts in navigating the SABS, ensuring that the reports prepared by health care assessors that comply with what is required under that regulation. Those reports must consider the clinical component of the injury in the context of the prevailing version of the SABS and other legal issues that accompany an assessment. This component of the care and treatment of injured claimants is not what hospitals are currently engaged in. It is however, what we do and what we have done for 25 years.

**8. Hospital Based IMEs:**

We understand that the government has no interest in pursuing a hospital-based IME system. For all of the reasons contained in our previous submissions on this issue, we support that policy position and are grateful to have had the opportunity to engage with your Ministry in that regard. Nevertheless, given that your government is committed to ensuring that businesses in Ontario are able to operate in the most efficient and cost-effective manner, we would offer one more reason for ensuring that hospital-based medical assessments do not form part of the reform of the auto insurance product.

Moving to a hospital-based IME system would regionalize, and in so doing, fragment and increase, the administrative costs of managing medical assessments. There is a substantial cost associated with administering every service that we perform. If HVE's administrative processes, file preparation and quality assurance systems were administered in individual regions of the province in which we operate, administrative costs (i.e. the cost above the medical assessor's cost) would increase significantly. Certainly, they would increase if those administrative services were divided between 7-10 hospitals or more. Even assuming that the costs increased by 10%, applying that increase against the many assessments that are required under the SABS would result in a massive cost increase to the system. Insurers have recognized the need to centralize the administration of IMEs in order to reduce costs. In fact, they have demanded that HVE be structured on a national basis for this purpose, and we have done so.

We know that there are still some stakeholders who argue in favour of hospital-based IMEs but we hope that the government does not entertain that policy change as it tries to reform the auto insurance product in a manner that benefits consumers in this province.

We would like to thank you for the opportunity to make this submission and look forward to working with your ministry and FSRA in the coming months and years to improve the effectiveness and efficiency of the treatment and care of accident victims in Ontario.

Yours truly,



Doris Vernon

President

HVE Healthcare Assessments



Brian M. Le Drew

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HVE Healthcare Assessments