Ontario Rehab Alliance

FSRA Health Claims for Auto Insurance (HCAI) System Review

Ontario Rehab Alliance Submission

November 28, 2024

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- ID: 2024-011 - Consultation on Auto Reforms
- **https://www.fsrao.ca/engagement-and-consultations/consultation-auto-reforms**

Emailed to:

FSRA

- Chris Georgakopoulos, Director of Auto Policy, FSRA

Ministry of Finance

- Francisco Chinchon, Assistant Deputy Minister, Financial Services Policy Division
- Taylor Putnam, Director of Budget & Strategic Initiatives
- Corey Naimark, Manager, Property & Casualty Insurance Policy

Reference: Link to Consultation Paper

Introduction

The Ontario Rehab Alliance represents primarily small to medium sized healthcare businesses that collectively employ upwards of 4000 healthcare providers. We are unique among the other provider associations in our sector as we represent licensed HSP organizations that provide the services of Regulated Health Professionals from all disciplines working in this sector along with Attendant Care (PSW) and rehabilitation support providers. Within the auto insurance sector most of our members services' focus on non-CAT and CAT clients. Some provide services through PPNs.

Most of our members work throughout the healthcare system providing services within multiple payor systems in addition to auto insurance, including WSIB, Veterans Affairs (VA), Long Term Care, Extended Health Plans, and private (self-pay), providing us with insight into compensation, recruitment and retention challenges, and related indirect costs.

Our mix of multi-discipline RHP and non-Regulated (Attendant Care, Rehab and Behavioural Support, etc.) members, in addition to cross-sector experience, gives us a wide-angle view of our healthcare ecosystem and a deep knowledge of the factors in play throughout it.

We are the only association focused primarily on the interests and issues of health providers in the auto sector.

Initiative A: Prioritize Increasing the Number of Forms Transmitted Through HCAI

The rationale for increasing the number of forms transmitted through HCAI makes excellent conceptual sense for all the reasons identified in the discussion paper and we fully support this goal.

However, doing so with HCAI in its current state does not make sense. Using HCAI is currently a disincentive to providers considering FSRA licensing. FSRA's discussion paper captures many of the issues. These should be addressed before putting additional load on this outdated system.

Feedback from our members suggests that prior to increasing the variety and volume of forms transmitted through HCAI priority should be given by FSRA to updating HCAI program coding and transforming it into a fully integrated system. We discuss this more fully later in this submission.

Initiative B: Prioritize Revising Forms

Revising Forms

We support revising forms for the many credible reasons outlined in the discussion paper. It is vital that the HSPs who use these forms be meaningfully included in this process to ensure that drop downs and other features are properly populated and that the intended outcomes will be achieved. Pre-populating forms and consolidating forms as much as possible should take place.

In particular, we suggest prioritizing the following form changes:

OCF-18

As recommended in our submission to the consultation on PSG, AC and MIG rates the OCF-18 should be revised to allow *all Regulated Health Professionals involved in the assessment and treatment of MVA claimants to sign treatment plans*. The current situation which, for example, requires Registered Nurse Case Managers or Registered Massage Therapists to have OCF-18s signed by a member of another discipline (one of the listed Regulated Health Professionals) who do not share the same scope of practice) is not appropriate professionally makes no practical sense, and adds an additional and unnecessary step that merely complicates and delays access to care.

Form 1: Assessment of Attendant Care Needs

While a thorough review of the Form 1 is due, we appreciate this will be a substantive and resource-intensive activity. At the time FSRA is ready to initiate that process, we suggest striking a Form 1-specific working group composed of healthcare provider and insurer stakeholder representatives. The ORA would be pleased to participate and bring our combined experience as Nurse Case Managers, Occupational Therapists (who generally complete Form 1s) and Attendant Care providers to that project.

In the meantime, it is urgent that the language on the form be revised to clarify that the Form 1 is intended to merely provide a tool for calculation of a quantum value of monthly care requirements within the AC monthly allowance caps. This was previously noted in the Revised Attendant Care Hourly Rate Guideline and Clarification of Health Care Providers Providers Subject to the Professional Services Bulletin No. A-03/18 and Superintendent's Guideline No. 01/18 issued by FSCO on April 11, 2018.

Use of the Form for calculation of benefit quantum must be clearly divorced from billing and payment processes.

The Form 1 was not designed nor intended to dictate payment amounts nor invoicing and payment procedures. Despite the aforementioned regulatory guidance to this effect, the past number of years have seen an increase in insurer demand that providers itemize their invoices in a line-by-line adherence to the levels and minutes used for calculation; this often runs contrary to the reality of how personal support is provided and puts an undue administrative burden on providers.

Reviewing Codes

Reviewing codes is one of the items listed under considerations for revising forms. We suggest that it be viewed as a distinct activity. This will be a tremendously intensive exercise. A number of ORA members were involved over the prolonged period when HCAI codes were developed in conjunction with insurers, HCAI and FSCO staff. As with all data, any information gleaned is only as good as the inputs. We also spent considerable association resources providing members with guidance and resources to support proper code use. We are unsure if insurers conducted or conduct similar education with adjusters.

Over the past number of years HSPs have been dealing with escalating denials when billing against a cluster of codes (the 7sf codes) with adjusters noting or citing company policy with the rationale that these activities are not bona fide treatment activities but rather are a 'cost of doing business'. This begs two questions:

Clarification must be issued that indirect treatment, including provider communication is not only permitted but a vital part of provision of healthcare. Insurers who ignore such guidance should be held to account.

Billing codes that make sense to providers and insurers, and that adjusters treat with respect, are vital.

Initiative C: Prioritize Data-related Initiatives

The ORA has long advocated for improved data to better support policy and regulatory developments and ensure future changes are data-driven and evidence-based.

We do not believe that HCAI is suited to or should be used as a tool to proscribe clinical activities but it is ideally positioned to capture data to illustrate trends and identify obstacles to system effectiveness and efficiency and help to ensure that claimants needs are promptly and appropriately met. Once properly updated and expanded into the integrated tool for transmission, communication and analysis that we envision, the following types of data should be collected:

- Wait times for
    - Initial access to care
    - Length of time for catastrophic designations

- Number of IEs by:
    - Claim

    - Injury type

- Denials
    - By type rates, brokerage, travel, etc)
    - By source (insurer)

- AB Limits, Discharges
    - Real-time date on AB usage including attendant care and med rehab accessible to claimants, HSP providers and insurers
    - Numbers of claimants who exhaust accident benefits before rehabilitation goals have been met
    - Types of injuries/claimants who exhaust accident benefits before rehabilitation goals have been met

Initiative D: Prioritize Other Initiatives

As outlined above we strongly recommend transforming HCAI into an updated, expanded and robust integrated portal for transmission, communication and analysis that can meet the information and activity needs of claimants, providers and insurers. Consideration should be given to expanding HCAI to a portal that contains all AB claims related communication . For example:

1. Existing forms
2. Additional forms not currently included
3. Uploaded reports - all (assessment, progress, closure)
4. Updates to replace email and telephone
5. Transmit questions and ad hoc requests by providers to insurers and vice versa reverse.
6. Transmit IE's and EOB's

Analysis of data should enable quantifiable insights into claimants' experience (pathway) and practice and policy impacts.

HCAI System Review Consultation Questions

1. Which initiative(s) should be prioritized? Why?

Initiative D.

2. Are there any significant benefits/drawbacks, including potential stakeholder impacts, missing from the analysis set out above that should be included?

Changes will require an investment of time by all involved in forms and system development but we foresee significant time savings and efficiencies once fully operational.

3. Are there any considerations which have been missed as part of the analysis set out above that should be included?

Claimants should be provided with access to HCAI, specifically the portions of it that will allow for:

- Current information about the use-to-date of their accident benefits
- Capacity to review treatment-related invoices; this will enhance transparency and, most importantly, enhance fraud detection.

We emphasize the point made earlier in this document of the need for meaningful engagement of current HSP licensees and insurers on changes to system content (forms, billing codes, etc.) and functionality.

4. What are the key implementation considerations that must be taken into account for each initiative (i.e., timing, communication, education, etc.)?

Key considerations for transition to the updated integrated system we recommend should include:

- Consultation during development with all users and Practice Management Software vendors
- Testing involving all user groups
- Development and delivery of video tutorials and webinars to support orientation
- Technical support including FAQs and live chat/phone

5. How can FSRA help to ensure that prioritized initiatives / changes are communicated to HSPs, insurers, and other stakeholders?

We expect that FSRA's usual communication channels to insurers and HSPs, along with industry newsletters such as the ORA's and similar insurer mechanisms will suffice. Presumably FSRA can mine contact information for other stakeholders gleaned from this and past consultations and reach out to consumers through its existing mechanisms.

6. Are there any other opportunities for administrative and cost efficiencies that FSRA should consider to make the HCAI system more modern and efficient that are not included in the list of initiatives above?

- HCAI and HSP licensing software should be integrated, enabling pre-population of fields, etc.
- Updated to facilitate:
    - 2-way dialogue between HSPs and insurers and HSPs and claimants
    - Automatic notifications (eg. approvals, messages, etc)
- Allow more status updates on invoices - once approved, show "payment made" for clearer communication to providers.
- Permit attachments (PDF's) to be submitted along with OCF 18's which negates the need for a separate fax.
- Link the invoice component of HCAI to a back end Electronic Funds Transfer payment
- Notification when a file is going to settle.
- Access to all OCF-9 - Explanation of Benefits
- Ability to withdraw OCF-18s and OCF-21s that have not been responded to
- Client designation of CAT or Non CAT

We are pleased to have had this opportunity to provide comments and welcome any follow-up questions or consultation.

Sincerely,

Laurie Davis
Executive Director