MUSIC THERAPY TORONTO

Hello FSRA,
I am a Registered Psychotherapist and Neurologic Music Therapist with 26 years of clinical experience. For the past eleven years, I have worked as a Health Service Provider (HSP) in the auto-insurance sector.
Thank you for the opportunity to share my observations on the challenges within this system which urgently requires attention and reform.

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1) Professional Rates
It is unacceptable that most health professionals working in this sector have not been allowed to increase their rates in over 10 years. While most of us have our rates firmly set by the Professional Services Guideline (PSG), some of us—like myself as a Registered Psychotherapist (RP) —are subject to the discretion of individual adjusters. The need to negotiate a new rate (and create different versions of individual practitioners with different rates in HCAI, is an unreasonable administrative burden).

This creates inconsistencies and inequities:

- Some/most adjusters approve treatment plans at my current rate.
- Other adjusters insist on arbitrary rate reductions (e.g., $0.08/hour, $15/hour, or even insisting that I work for less than half my standard rate, if they are to approve the treatment plan).

This untenable situation is exacerbated by unprecedented inflation and post-pandemic burnout in the healthcare sector. For a regulatory body like FSRA to enforce stagnant professional rates for a decade is unsustainable and deters qualified professionals from remaining in this field, which ultimately impacts patient outcomes.

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2) Insurance Maximum Payouts for Medical Rehabilitation
Over the past decade, costs associated with medical rehabilitation (other than professional fees) have risen, yet:

- Maximum payouts for claimants ($1 million or $2 million, depending on coverage) remain unchanged.
- HSP professional fees have been stagnant.
- Insurance companies, however, have been allowed to raise premiums by 34.5%.

This double standard is glaring. In 2018, the Conservative government promised system reforms and premium reductions. However, the changes merely allowed optional reductions in catastrophic coverage limits (e.g., from $2 million to $1 million), shifting risk to consumers who were often unaware of the potential long-term costs of rehabilitation.
Insurance companies have teams of actuaries and access to extensive data, while consumers lack this expertise. This underscores why regulators must prioritize the interests of consumers over corporate profits.

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3) Inadequacy of Catastrophic and Non-Catastrophic Categories
The distinction between catastrophic (CAT) and non-catastrophic (non-CAT) injuries does not align with the lived experiences of many patients:

- The $65,000 non-CAT threshold is inadequate for many patients (who don't meet the CAT criteria) requiring extensive rehabilitation.
- A significant gap exists between $65,000 and $1 million. Patients frequently exhaust their non-CAT coverage before being designated as catastrophic, leading to delays in essential care. Many patients don't meet the criteria for CAT, but exhaust their med-rehab benefits long before their rehabilitation is complete. Why is there not a middle category with $300K of med rehab available?

Additionally, PSG rates differ for CAT and non-CAT cases. This is counterintuitive:

- In my 26 years, I have never encountered another healthcare sector where hourly professional rates vary based on injury severity.
- HSPs should be compensated for more complex CAT cases, but this happens because we incur more billable hours when working on CAT cases. Greater compensation for more complex cases comes from more time spent on those cases. Paying HSPs less for non-CAT cases creates a disincentive to working on those cases.

If the distinction in rates is maintained however then, the non-CAT funding cap urgently needs a substantial increase, and PSG rates should be immediately and substantially adjusted to attract qualified HSPs to this sector.

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4) Inefficiencies of the HCAI Platform

The HCAI platform is outdated, inefficient, and poorly designed, and very awkward to use. This places unreasonable administrative burdens on providers, claimants, and adjusters. Key issues include:

- Claimants and providers cannot sign OCF-18s directly within the platform, requiring time-consuming external processes.
- Providers have no way to view remaining claimant rehab funds, leading to wasted resources when treatment plans are submitted on exhausted accounts.
- There is no direct communication channel (e.g., a messaging system) between adjusters and HSPs within HCAI, which could reduce delays and errors.

Modern technology offers solutions that HCAI has failed to adopt. A redesigned platform could:

1. Allow claimants to log in, review, and sign OCF-18s electronically.
2. Enable team members and claimants to see how much of a claimant's rehabilitation funds remain. This is especially important with non-CAT cases.
3. Facilitate secure messaging between adjusters and providers (similar to how the CRA portal works and communicates with tax payers) and providers and claimants.

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5) Barriers to Accessing Qualified Providers

HCAI inefficiencies, below-market PSG rates, and administrative hurdles deter excellent providers from working in the auto-insurance sector. This limits access for claimants and prolongs wait times, particularly for essential independent evaluations, which of course then had an adverse impact on patient outcomes or at least delays the rehabilitation process thus increasing health care costs.

For example, one of my pediatric clients with significant injuries has been waiting eight months for a neuropsychological assessment required for catastrophic designation. This delay, caused by a lack of available providers, has halted critical treatments. The entire treatment team is waiting for a CAT assessment to take place so that treatment can resume. The adjuster has been looking for a neuropsych assessor to do the assessment for 8 months.

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6) Challenges in Treatment Plan Approvals and Redundant Regulatory Burden

I am a Registered Psychotherapist and certified Neurologic Music Therapist (NMT) with advanced training (including a masters' degree) and 26 years of clinical experience. I frequently encounter adjusters who:

- Admit to knowing little or nothing about NMT.
- Approve treatment plans inconsistently or delay them by sending plans for Independent Examinations (IEs). They say that they cant approve a treatment plan when they know nothing about the treatment program (despite the fact that I always provide them with a substantial introductory and information package).

This is unjustifiable when treatment plans are referred by regulated professionals (e.g., PTs, OTs, SLPs, MDs) and supported by the patient and their team. Adjusters without medical or rehabilitation training should not have the authority to veto plans for evidence-based, regulated therapies like NMT. As a Registered Psychotherapist my ethical and professional conduct is already regulated by the CRPO, the other HSP on the treatment team who referred the patient to my services are PTs, SLPs, OTs and MDs, who are also regulated by their regulatory colleges. If any of us are acting improperly or unethically our regulatory colleges are ready to receive complaints and to follow up with appropriate discipline. Why do the insurance companies need another layer of expensive regulation (money that could be better directed to patient care) ? This often results in significant delays to patients accessing needed rehabilitation services.

Delays in accessing necessary treatments negatively impact patient recovery and further strain the system. This additional layer of regulation is costly, redundant, and detracts from patient care.

Further, it seems that individual adjusters are given the authority and great discretion to interpret FSRA rules and regulations and their company policies. For example, I have submitted a treatment plan to an insurance company and it is approved with no problems, then an other plan for a different client at the same company is submitted for a client with a similar degree of injury (but a different adjuster) who insists that my treatment plan will only be approved to match a rate that is in the PSG (even though RPs are not listed in the PSG). There was a period two years ago when I sent several treatment plans to the same company. I was told that the plans would be approved if I worked for half of my regular rate, which I can not do, so my treatment was not available to those patients. Those patients might have had the plans approved with no issue had they been with a different insurer. This presents a huge equity issue for consumers, as most will choose insurance based on cost and costumer service during the purchasing process. Auto-insurance consumers in

Ontario have no possible way to vet insurance companies on what is the most important metric. If someone is seriously injured and needs med-rehab did they choose an insurance company that will provide for their needs, or did they choose a company that puts up barriers to accessing their care. Sometimes this seems to vary from one company to the next but to make matters worse this sometime seems to vary from one adjuster to the next within the same company. This is the most important consideration in choosing insurance and Ontarians have no way to vet their insurance purchase in this regard.

Conclusion

The auto-insurance- health care- rehabilitation system urgently needs reforms to address:

1. Fair professional compensation.
2. Adequate rehabilitation funding for both CAT and non-CAT cases.
3. An additional injury category to bridge the huge gap between CAT and non-CAT cases.
4. The redundant regulatory burden that FSRA (and insurance companies – through unnecessary IEs) impose on HSPs that is already covered by our regulatory colleges.
5. Modernization, rebuilding of HCAI to reduce inefficiencies.
6. Barriers preventing timely access to qualified providers.
7. The unjustified and arbitrary power of adjusters to delay or deny evidence-based treatment plans, and to have large discrepancies between adjusters in how the rules are applied and interpreted.

Thank you for considering this feedback. I hope FSRA will prioritize the needs of claimants and health service providers in these critical reforms.

Sincerely,

Aaron Lightstone MMT, RP, MTA, NMT-F
Registered Psychotherapist and Certified Neurologic Music Therapist
Music Therapy Toronto
