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Senior Manager
Automobile Insurance Policy Unit
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Ministry of Finance
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RE: Ontario Automobile Insurance Dispute Resolution System Review Submissions

I am a physician-stakeholder with extensive involvement in the assessment of injured motor-vehicle accident claimants under Ontario's No-Fault Insurance system.

My particular professional interest has been in the assessment of claimants injured in automobile accidents and in their access to reasonable and necessary benefits under all of the No Fault auto insurance schemes introduced since 1990 of Ontario. More recently, I have made submissions to FSCO regarding their Report of the Catastrophic Impairment Expert Panel to the Superintendent as well as to the Legislative Standing Committee on Finance and Economic Affairs.

My extensive involvement over the past two and a half decades as a physician stakeholder has given me a unique yet independent perspective on some important matters. In particular, I would like to submit for your review my thoughts on improving the "Independent Medical Examination" issue. My recommendations are simple: Reconstruct the previous extensively developed and successful DAC system, with some relatively minor changes to address concerns of insurers and plaintiff's counsel, adjust the vetting system by FSCO of rostering physicians and other health professionals, and meld this with a variant of the fairly simple system introduced in the state of Colorado almost twenty years ago.

Who am I to suggest a new assessment model?

I am an adjunct assistant professor in the Faculty of Medicine at the University of Toronto. I am also a trained scientist with a rigorous undergraduate science education and two advanced post-graduate degrees including a PhD in Medical Biophysics.

I am a past president of the Medicolegal Society of Toronto.

I have spent more than 20 years working exclusively in the assessment of claimants under the various No Fault Auto Insurance schemes since the Ontario Motorist Protection Plan was launched in 1990. I was the Ontario Medical Association's representative on the Minister's Committee for the Designated Assessment Centre System (Minister's DAC Committee) from 1996 through 2001, retiring as Vice Chair. While a member of the Minister's DAC Committee, I was the chair of the working group that authored the Catastrophic Impairment Assessment Guidelines used throughout Ontario until the DAC system was disbanded in 2006. I also served as the medical representative on the Advisory Panel that wrote the Report on the Redefinition of Catastrophic Impairment to the Minister of Finance released in 2001.

One problem that requires fixing -- the "Independent Medical Examination"

There have been ongoing concerns regarding the quality and independence of medical examinations of injured claimants. So much so that the term "IME" no longer represents "Independent Medical Examination" but is now used to represent "Insurer Medical Examination". The integrity of the system used to evaluate access to insurance benefits has lost the confidence of consumers.

For years, the insurance industry has relied on a model of IME's in their efforts to adjudicate payment of benefits to injured claimants. This used to involve the insurers' choice of assessor but evolved into a "broker" system where insurers chose an assessment company who then assigned an assessor to the referral. In my opinion, and in the opinion of many legal representatives, this was a simple yet veiled attempt for insurers to "insulate" themselves from accusations of preferentially selecting IME providers who would provide preferred opinion to them. While this allowed insurers to pretend they were isolated from those actions, in fact, the move to IME "brokers" merely moved the accusations of bias from single assessors to assessment companies.

Successful past models for IME's

In 1994, a brilliant assessment model was introduced in Ontario, a model that addressed issues of selectivity and quality of independent assessment of accident victims. This was the "DAC" (Designated Assessment Centre) system which was overseen by the Minister of Finance through the establishment of a Minister's DAC Committee. I have written additional details of the work of the DAC Committee further in this document.

The DAC system for more than ten years, from 1994 through 2006, and developed extensive infrastructure for assessment of claimants. Guidelines for assessment for med-rehab, disability, and attendant care benefits as well as access to catastrophic impairment designation were extensively developed and fine-tuned. In turn, these underwent legal interpretation via arbitration decisions. The DAC system evolved into a comprehensive and successful structure of claimant evaluation before it was finally disbanded by FSCO. Nothing was put in its place and the present IME system has prevailed subsequently.

In 1996, an American Model for independent medical evaluation was developed by the State of Colorado. This, too, evolved out of dissatisfaction of perceived bias of insurers in determining access to auto insurance benefits by claimants. The "Colorado Model" provided claimants with an independently developed list of five authorized "IME" health professionals. The list was "whittled down" by each side deselecting two names at a time until the last name on the list became the *de facto* IME provider.

I have provided some material on the Colorado Model in Appendix II and III.

The historical evolution of the assessments of claimants over the past 20 years.

The assessment of insured claimants is seen by many to be problematic and has been so for many years. While the insurance industry has tackled the problem for decades, the issue has become more difficult than ever as the assessment of accident victims has evolved far beyond the single orthopedic

examination of the 70's and 80's to now involve more advanced and increasingly complex multidisciplinary evaluations. This shift has come about as a result of advances in evidence-based medicine that acknowledges that there is much more to accident-related injuries than what was appreciated as "whiplash" in decades past. Many frontline studies have shown that recovery from complex injuries must involve a multidisciplinary approach to rehabilitation that includes not only physical and psychological recovery but also functional restoration.

Indeed, the Statutory Accident Benefits Schedule directs rehabilitation "**that (is) reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market**."

In an important acknowledgement, the Insurance Bureau of Canada (IBC) in their submission to you has recommended the **Creation of a Medical Expert Panel** (see Appendix I). Their submission states, in part:

> "Currently arbitrators do not have access to a neutral benchmark for the generally expected medical course for claims under the SABS. We propose engagement of an independent and unbiased medical expert panel, mandated to provide insight on the evidence-based state of medical knowledge. The panel would inform the process as to the nature of a particular claim with reference to generally accepted medical norms. A medical expert panel would assist to expose abuses within the system, and provide benchmarks and education for the benefit of the arbitrators and other users of the system.
>
> …The statutory authority for creating such a Panel already exists. The Insurance Act allows the Minister or Superintendent to appoint a Minister's committee to perform whatever functions are assigned to it. Using this authority, it would be possible to create a committee of disability and rehabilitation experts to perform a screening function with respect to cases coming through arbitration."

Indeed, such a panel was struck in the mid 1990's under the Minister of Finance, but was not limited to only "medical" experts. Following the introduction of a comprehensive first party No Fault compensation system in 1990, and subsequent tweaks by various provincial governments since, Ontario introduced a system of "Designated Assessment Centres" (DACs) in 1994. The DACs were administered by a Minister's Committee of Health Professionals along with representatives from the insurance industry, legal profession, consumer groups and government. This Minister's Committee was given the mandate to oversee DACs, to develop standards and guidelines for DAC assessments, to develop fee schedules and treatment protocols for DAC assessments, and to evaluate DAC performances. Stringent rules were put in place to prevent potential bias and to eliminate DAC interactions with insurers or plaintiff's counsel, and rigid conflict of interest guidelines were introduced in order to ensure the independence and neutrality of the DACs. Rules were established to ensure qualification of DAC assessors. The DACs were mandated to provide assessments that were "timely, impartial, comprehensive, and cost-effective". The Minister's Committee was responsible to monitor that DACs performed within these tenets and was given responsibility to remove DACs from the DAC roster if they did not.

According the original description of the DAC system, still available on the FSCO website,

> ”Designated Assessment Centres (DACs) have been in place across Ontario for automobile insurance companies and claimants to use when they need a neutral third-party opinion about a claimant's injuries and the accident benefits that apply to those injuries.
>
> DACs are authorized to conduct independent assessments that are designed to balance the interests of both insurance companies and claimants. Insurers are required to initiate and pay for the cost of the assessment, and the claimant is required to cooperate in the assessment process.
>
> The final report of the DAC is binding, and the insurer must adjust the statutory accident benefits to reflect the DAC findings. If a dispute still exists after the DAC assessment, the parties may use the mediation services at the Financial Services Commission of Ontario to try to resolve the dispute.”

Ask any of the arbitrators from FSCO’s Arbitration Unit how successful the DAC system was in the provision of evidence based, authoritative, and comprehensive assessment of rehabilitation needs, disability status, attendant care essentials and catastrophic impairment status when their findings came up in dispute resolution. Over the years that this system was in place, the professionalism of the DACs and efforts to ensure neutrality in the DACs became apparent. However, over the latter years of its mandate, resistance to its continuing operation grew from both insurers as well as from plaintiff’s counsel as more and more problems, both perceived and real, began to surface.

For example, insurers did not appreciate the loss of control of the costs of benefits provided to claimants as the decisions of the DACs were binding, pending formal dispute resolution. Perhaps this concern needs to be revisited in any new system.

Plaintiff’s lawyers were unhappy as they perceived that the DACs rejected most Treatment Plans and most Disability claims. However, with respect to the lawyer’s concerns, two things are important to note. Firstly, Treatment Plans and assessment of Disability requests were sent to the DACs typically after two years post-accident. Many of those Treatment Plans were rejected by Med-Rehab DACs because such late or passive treatment was not supported especially when it appeared that claimants were not receiving any further benefit from the recommended treatment. Secondly, by two years after the accident, claims for post-104 week Disability were not supported in the majority of cases that were assessed by Disability DACs as the claimants no longer met the test of disability (which was more stringent after 2 years post-accident). Interestingly, most claimants seen for review of Treatment Plans or assessment of post-104 week disability had been receiving treatment up to that point and had already been accepted as meeting the pre-104 week disability test and had been receiving disability benefits during that time.

Two further issues surfaced and were seen to be problematic. In order to ensure the neutrality of the DACs, insurers, who were responsible for sending the claimant to the nearest DAC, sometimes bypassed the nearest DAC and sent claimants to selected (preferred) DACs who tended to be oriented to the mandate of the insurers. These events went unnoticed by claimants who for the most part were

unaware of the closest DAC rule, and by lawyers who were unable to or just did not bother to determine if the closest DAC(s) were skipped over.

In addition, a major misperception by claimants that DACs were responsible to insurers came from the fact that DACs were paid by insurers. This resulted in the outcome that claimants mistrusted DACs from the outset.

We on the Minister's committee recommended to FSCO that the nearest DAC should be selected and monitored by FSCO and that DACs should be paid by an independent source (FSCO). Neither of these important issues was acknowledged by FSCO and, in my opinion, contributed significantly to the mistrust of the DAC system by the claimants it was meant to protect.

My Recommendations

Confidence in the present IME system has deteriorated to the point where disparaging articles are now appearing in mainstream media. The present Review of Ontario's Dispute Resolution System is a consequence of this corrosion of confidence. It is important for the integrity of the IME system that a new method of evaluating claimants be considered. My recommendations, below, involve for the most part, components of already tested models, such as elements from the previous Ontario DAC system and some fine-tuning of components from an assessment system introduced in Colorado in 1996. I would suggest the following for your consideration:

1. The DAC system that was introduced and refined for over a decade from 1994 through 2006 was an excellent model and should be resurrected with some additional controls. The DACs should be chosen in a manner that clearly establishes independence from both insurers and plaintiff's counsel. The "closest DAC" was seen to not be the best model. Rather, the most appropriate DAC qualified to undertake the assessment of the particular client should be the overriding concern. FSCO should have the mandate to characterize and roster multidisciplinary assessment centres as it did the DACs.

2. A model of DAC selection can be developed as a variant of the older, more complex "Colorado" model in which a list of five IME assessors was provided to the claimant and ultimately a selection was made by serial elimination. I would suggest serial selection from a list of three to five DACs be considered. In this model, the claimant chooses one and the insurer accepts or rejects that one. If rejected, the insurer selects the next one. The claimant then accepts or rejects that one. And so on. This method provides the unique result that each DAC on the list will have to become identified as a "fair" DAC by both insurers and claimants in order to be selected. This will naturally extend to the selection by each DAC of the quality and independence of its attending expert assessors. This system therefore is a self-adjusting one in which competition by the DAC to be selected as a reasonable choice by both claimant and insurer becomes predominant.

3. The DACs must be paid by a neutral body such as FSCO. Perhaps the referring party (insurer) could submit payment to FSCO and FSCO would pay the DAC after confirming, as a third party, the validity (cost) of the DAC invoice.

4. While there were over one hundred DACs of various sorts in the old system (disability, med-rehab, attendant care, catastrophic impairment), I recommend a much more streamlined population be identified. Problems with DACs in more remote regions of the province were identified as some undertook only a few assessments per year; in my opinion, while some provided excellent assessments, others fell short. A smaller, dedicated group of DACs would be easier to monitor and would more easily promote in-service collaboration with other DACs. Such successful collaboration was seen among the seven Catastrophic Impairment DACs in the "old system" These seven "CAT DACs" held "CAT DAC rounds" on a regular basis to exchange ideas, to improve quality and to maintain consistency of assessments across the system.

5. A roster of Health Professionals working in the new system would need to be vetted by FSCO, but perhaps more stringently than was done in the old DAC system as much of the vetting in the old system was left to the individual DACs themselves. By virtue of FSCO's central role, costs could be monitored and controlled. A central, government monitored system could allow for research and development of assessment models such that Ontario could become the flagship model for independent medical evaluation of claimants. As a benefit in the new system, "rogue" assessors whose opinions would be seen by various parties to frequently fall outside of the norm would be "screened out" by assessment centres vying to be chosen by insurers and claimants (see point 2 above). In this way, a degree of "neutrality" would continue to self-manifest in the system and could even work to rehabilitate such rogue opinions.

6. This new model would not only answer the IBC's recommendation for a new Minister's "independent and unbiased medical expert panel " but would improve on that by also including experts from the Health Professions, the legal bar, the insurance industry and FSCO, as was done most successfully in the previous Minister's DAC Committee. It would utilize evidence based improvements and safeguards that have been gleaned from ten years' experience coming out of the previous DAC system. It would introduce a hybrid model that would include not only the best elements of previous the DAC system but would utilize improvements from the Colorado model. It would instil confidence in a failing IME system and allow buy-in from all sides.

The introduction of a comprehensive model of assessment of injured claimants for the purpose of establishing access to reasonable and necessary benefits provided in our highly developed No-Fault auto insurance scheme, provides a unique opportunity to clarify, refine and conclude once and for all a comprehensive, stable, and fair first pillar in a successful dispute resolution system.

Thank you for your consideration of my comments.

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University of Toronto

Medical Director
Omega Medical Associates

Appendix I

Insurance Bureau of Canada |
Submissions for Proposed Reform to FSCO ADR Process
September 20, 2013

http://www.fin.gov.on.ca/en/consultations/pension/submissions/odrsrs/Insurance%20Bureau%20of%20Canada%20%28IBC%29%20-%20DRS%20Review%20submission%20-%20September%202013.pdf

Recommendation 2:

Creation of a Medical Expert Panel
Currently arbitrators do not have access to a neutral benchmark for the generally expected medical course for claims under the SABS. We propose engagement of an independent and unbiased medical expert panel, mandated to provide insight on the evidence -based state of medical knowledge. The panel would inform the process as to the nature of a particular claim with reference to generally accepted medical norms. A medical expert panel would assist to expose abuses within the system, and provide benchmarks and education for the benefit of the arbitrators and other users of the system.

A.
Statutory Authority for Creating a Medical Expert Panel
The statutory authority for creating such a Panel already exists. The Insurance Act allows the Minister or Superintendent to appoint a Minister's committee to perform whatever functions are assigned to it. Using this authority, it would be possible to create a committee of disability and rehabilitation experts to perform a screening function with respect to cases coming through arbitration.

B.
Role of the Medical Expert Panel
The role of the medical panel would be to conduct a paper review of the particular claim for healthcare and disability costs, and to provide a report simply to set out the parameters of the expected norms typically associated with the claim, founded on medically-based evidence. The report would not prejudge the outcome, but would set the context for evaluating the claim on its merits. In particular, the report would establish the following:

- Whether the type of impairment diagnosed is a common diagnosis,
- Whether the disability alleged in relation to the impairment is the kind of disability, both in terms of character and duration, normally encountered for this diagnosis of injury,
- What the normal modalities of treatment are for such injuries, as well as the frequency and cost of the treatment based upon similar claims grounded in evidence based medicine,

- Whether the diagnosis is one normally made after an event such as the accident In question, and
- Additional comments on the treatment offered and claimed.

The report would provide an anchor or benchmark regarding the generally expected medical course for a kind of case. The arbitrator would then be in a better position to understand the assertions made by the parties, and determine whether evidence justifying the claim is required. Arbitrators would more easily recognize allegations that are outside of medical norms, and would accordingly be in a position to require cogent and convincing evidence to sustain the allegations.

The panel would also play an important role in assist with the elimination of abuses. For instance, it could be part of the panel's role to report issues of competence and dishonesty to the appropriate medical college. The panel could also make referral to investigators who might be charged with looking at any portrayed improprieties, promoting compliance with the SABS. Reporting such issues would result in a repository of intelligence identifying the players in t he system that appear to be repeatedly engaging in questionable practices. As indicated above, the involvement of the panel would be strictly limited to providing background for the arbitrator not to provide a judgment or assessment with respect to any of the actual entitlement issues. Furthermore, the panel would not be tasked with reviewing lengthy volumes of medical documentation for the purpose of preparing the report. Rather, brief summaries concerning the claimant's condition and course of treatment would suffice for this purpose, which would reduce the time and expense associated with this role.

C.
Qualifications of the Medical Expert Panel
As part of their role, the panel would be obligated to provide comments on the particular claim based on generally -accepted medical and scientific principles. In terms of who would qualify to be on the panel, panel members would ideally be nominated by their respective regulatory college, and be members or designates of their respective quality assurance committees

D.
Advantages of the Medical Expert Panel
There are a number of advantages to making use of the existing statutory authority to create a medical expert panel. Those advantages include the following:

- Neutral expertise is brought to each case, at a relatively low cost,
- A benchmark is created for the evaluation of entitlement in each case,
- The system users will become more educated about mainstream medical science and generally-accepted norms for the course of claims, and
- Abusers of the system will be identified and appropriately reported by the panel members.

Appendix II

The "Colorado Assessment Model"

http://tinyurl.com/Appendix-II)

(http://www.state.co.us/gov_dir/leg_dir/olls/digest1996/INSURANCE.htm#96-078)

Session Laws of Colorado 1996
Second Regular Session, 60th General Assembly

CHAPTER 146 **SENATE BILL 96-078**

Appendix III

Division of Insurance 3 CCR 702-5 AMENDED REGULATION 5-2-9 PERSONAL INJURY PROTECTION EXAMINATION PROGRAM

http://tinyurl.com/Appendix-III

AT PAGE 35 - this is a large document:

"Pip Examination Program: Effective January 1, 1997: Effective January 1, 1997, Colorado restricts the ability of PIP carriers to select IME examiners. The PIP examination program is the exclusive method for obtaining an independent medical examination from a health care practitioner other than a treating provider relating to a disputed PIP claim.

The PIP examination program is conducted under the supervision of the Colorado Commissioner of Insurance, which is to provide a group of licensed health care practitioners to serve as the PIP examination review panel. A health care practitioner participating in the PIP review panel shall be actively engaged in the practice of his or her profession and the majority of such practice and income shall not derive from witness fees and examination of persons not under the practitioner's care and treatment. It shall be the duty of the PIP examination review panel to perform the PIP examinations at the request of the commissioner. See C.R.S. § 10-4-706(6)(b).

Any insurer, insured, or injured person entitled to benefits has the right to obtain a PIP examination with the health care practitioner from the PIP examination review panel regarding each type of treatment involved in the disputed portion of the PIP claim. When submitting the request for a PIP examination, the requesting party shall specify the professional specialty of the health care practitioner who will perform the PIP examination. Where practical, such professional specialty shall be the same as that of the treating health care practitioner whose treatment and opinion are intended to be reviewed by the member of the PIP review panel; except that psychiatrists, psychologists and neuropsychologists may review one another's treatment and opinions to the extent that the reviewing expert is qualified to address the specific issues which arise in a particular case. Nothing in this section should preclude a managed care organization from using its usual and customary review procedures. See C.R.S. § 10-4-706(6)(c).

Though a revolving selection process established by rule, the commissioner shall prepare a list of five health care practitioners qualified to perform the PIP examination, and submit it to the requesting party. Within five days of receipt, the requesting party shall strike two names from the first list and submit it to the opposing party. Within five days of receipt, the opposing party shall strike two names from the list. The opposing party shall immediately return the list to the commissioner. The insurer and insured or the injured person entitled to benefits may agree upon a health care practitioner to perform the PIP examination without using the revolving selection process. Upon the selection of the health care practitioner, the PIP examination shall proceed and the requesting party shall pay the cost of the examination. See C.R.S. § 10-4-706(6)(d).

The PIP health care practitioner shall determine whether the treatment that has been rendered to the insured or injured person entitled to the benefits is reasonable, necessary, and if such claimed injury or condition arises out of the use of a motor vehicle. See C.R.S. § 10-4-706(6)(e).

A health care practitioner who performs a PIP examination pursuant to this subsection shall be immune from civil liability in any action brought by any person based upon such practitioners findings, opinions and conclusions, absent a showing of malice or bad faith on the part of the examining health care practitioner. See C.R.S. § 10-4-706(6)(f).

In the event the findings, opinions and conclusions of the PIP review panel member are contrary to the statement of causation, diagnosis, prognosis, plan of treatment, opinions, or recommendations of the treating practitioner whose actions have been reviewed, any party dissatisfied with such findings, opinions and conclusions may seek and pay for a second PIP examination under the procedures set forth in paragraph (c) and (d) of this subsection. See C.R.S. § 10-4-706(6)(g).

In any arbitration or judicial proceeding commenced by the insurer, insured or injured person entitled to benefits, the findings, opinions, and conclusions of the PIP examination shall be presumed to be correct, but such presumption may be rebutted by a preponderance of the evidence. If there has been a second PIP examination pursuant to paragraph (g) of this subsection, the agreed upon findings, opinions, and conclusions of two of three health care practitioners shall be binding unless rebutted by clear and convincing evidence in any arbitration or judicial proceeding commenced by the insurer, the insured, or the injured person entitled to benefits. No civil proceeding, including but not limited to, a proceeding alleging any cause of action under section 10-4-708 or the tort of bad faith breach of the insurance contract, arising out of any action taken by the insurer that is consistent with the agreed upon findings, opinions, and conclusions of two of three health care practitioners shall be brought or maintained against the insurer; except that the insured or injured person entitled to benefits may bring a civil proceeding alleging that clear and convincing evidence rebuts the findings, opinions, and conclusions of the two of the three health care practitioners.

If the insured or injured person entitled to benefits is successful, the no-fault insurer shall be obligated to pay the no-fault benefits that have been denied and that were the subject of such proceeding. See C.R.S. § 10-4-706(6)(h).

Releases: If there is both liability and a PIP claim, the release must specifically refer to releasing the PIP claim. See Cingoranelli v. St. Paul Fire and Marine Ins. Co., 658 P.2d 863 (Colo. 1983).

In Colorado, third parties do not have a right of direct action against an opposing party's insurance carrier. Therefore, there is no need for the insurer to be listed on releases executed by third parties..."