Ontario Rehab Alliance

FSRA Statutory Accident Benefits Schedule (SABS) Guidelines Review

Ontario Rehab Alliance Submission

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- 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 Here

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 Regulated Health Professionals from all disciplines, along with personal support and rehabilitation support workers. 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 the 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.

The ORA is very appreciative of this long-overdue review of the Guidelines papers and of FSRA's objectives. Namely, prioritizing the key principles of:

- Maintaining the care that consumers receive
- Ensuring the continued availability of services

These priorities in turn align with FSRA's overarching mandate to protect the rights and interests of auto insurance consumers.

Our responses to the consultation questions that follow flow from our analysis of how the current Guidelines meet, or fall short of meeting, these objectives.

Maintaining Consumer Care

As healthcare providers in the auto insurance funded rehab sector we differentiate 'consumers' from 'claimants' in our analysis. Recognizing that it is vital for consumers to be able to purchase affordable coverage we are deeply concerned with the lack of information and insight most consumers are provided with at point of purchase/renewal. Not until consumers are transformed by an accident into claimants do they fully appreciate the impact of purchase-point decisions. It therefore falls to the government, as the crafter of the mandatory product to ensure this objective is met through responsible policy and product design.

While updating Guidelines is critical to maintaining delivery of consumer care at the individual claimant-HSP level it is the design of the product that impacts whether or not injured consumers can in fact obtain that care. Though outside the scope of this consultation paper we are compelled to note that the recent regulatory changes making an array of often-necessary benefits optional will have dire consequences for maintaining consumer care at the societal level.

Claims handling practices by insurers are another key aspect of maintaining consumer/claimant care which is outside the scope of this consultation but is vital to continuity of care and the ecosystem in which these Guidelines operate. Continuity of care is a cornerstone of quality healthcare. When in place it allows for the development and maintenance of a relationship between an injured person and their treatment providers and their treatment plans and goals. In today's climate the priority of maintaining care is frequently disrupted by arbitrary denials, many of them rate-based.

Further, we stress the importance of insurer claims handling practices as a criteria to be investigated as a part of any accreditation process to be undertaken by FSRA for rate filings and underwriting. Claims handling practices are of necessity an integral part of the value of any auto insurance product. *Please see our submission to FSRA's consultations on the Fraud Reporting Service and Rating and Underwriting Supervision for related commentary.*

Continued Availability of Services

Updated pay rate guidelines and payment processes are essential to maintaining the health and sustainability of the HSPs in this sector which is in turn essential to maintaining claimant care.

As the ORA has previously written in our submissions to FSRA and the Ministry of Finance over the past years, the health and sustainability of HSPs is in crisis due to our incapacity to appropriately compensate both regulated and non-regulated providers.

This crisis is best articulated as a highly competitive recruitment and retention environment and grossly non competitive fees. Foundational components include:

- Companies and individual providers migrating to work in other, more competitively compensated, payor systems and jurisdictions

- HSPs who treat seriously and catastrophically injured clients have been leaving the sector and/or diminishing their involvement significantly for the past cluster of years.

- The education, skills and experience levels needed to work with the seriously and catastrophically injured demographic are not those of new grads or those with less than a number of years of experience; competing for these more senior clinicians and mature support personnel (PSW, rehab assistants) requires requisite compensation.

- The supply of all those who work on the front lines of rehab is constrained, if not more so, than the supply throughout the healthcare ecosystem in Ontario and across Canada.

- The cost of recruitment, onboarding and training have escalated due to the insurance systems' complexities during the past 10 years

Current Compensation Differentials

The table below illustrates as close to a like-to-like comparison as possible given the different variables in play. For instance: we are using the non-CAT PSG rate as those comprise 98% of claims; multiple codes are available for each discipline in different systems, this analysis selected codes comparable in scope and complexity to MVA.

	MVA/PSG	WSIB	LTD	WSBC	ICBC	Private	Association	VA
PT	$99.75	$93.10*	$140-$150	$120	$145	$150 - 183	$150- $183	$100-$120
OT	$99.75	$152.07	$132-$155	$127	$136	$120-$130	$150	$140
SLP	$112.22	$93.10*	$190-$205	$140	$140	$150-$160	$207	$120
SW	N/A	$139.00	$160-$245	$140	$140	$175-$225	$150	$200

*Actively being reviewed for increase by WSIB
"Association" refers to comparable rates recommended by each discipline's professional association; several of these have not been updated in a number of years.

We have often heard, most recently on this consultation's webinar, that MVA rates might be examined through a comparison with those WSIB. These random comparisons are uninformed. Rates must not be cherry-picked to conform with a confirmation bias of lower rates. Rather, rates for work that are comparable in scope should be used for comparison. Consideration must

be also given to the fact that auto insurance HSP work carries higher costs due to system complexity, additional regulatory costs etc.

Currently, PSG rates are lower than similar scope rates in other systems which do not carry these additional costs to HSPs.

In the fall of 2022 the ORA surveyed its members on these issues. Responses clearly illustrated the challenges described above. Further, the findings showed that HSPs were either planning to leave the sector or to reduce the proportion of work they do in this sector.

Respondents reflected the demographics of our membership at the time with approx one-quarter from each of our membership levels of sole practitioner, 2-5 FTE clinicians, 6-15 FTE clinicians and more than 16 practicing clinicians. Respondent provider settings included clinic (17%), community (39%) and a combined clinic/community practice (44%). Collectively, they provided services across all disciplines and service types.

Key findings:

- Reported higher rates of pay in similar, multiple non-MVA payer systems
- Consensus that MVA sector has more red tape and administrative burden
- Recruitment and retention issues identified as paramount concern
- Compensation reported as the number one issue in recruitment and retention
- Majority indicated that they were making plans to become less reliant on revenues from this sector and cited the factors contributing to this decision

Please refer to these findings in full here and attached the end of our comments.

All reports indicated that these issues and trends have become even more heightened in the three years that have elapsed since the survey was administered.

The above factors contribute to problematic trends, including:

- Delays to treatment of seriously injured claimants
- Higher likelihood of re-injury;
- Acute turning into chronic conditions;
- Delays in return to work, school etc.

- Increased litigation and higher settlement amounts
- Transfer of costs from auto insurers to the public sector

Updating HSP Rates & Premium Cost Concerns: A Red Herring

The discussion paper positions this consultation on updating pay rates within a context of concern about auto insurance affordability. If the regulator and the Ministry of Finance is concerned about escalation in premiums, why have insurers been permitted to raise premium rates by 35% while CPI increased by 29% since HSPs last increase in 2014?

Surely this can't be seen as either logical or equitable? Either there should have been a commitment to freezing rates and disallowing all stakeholder increases for the past decade or consistent and equitable measures to allow increases for all should have been enacted. Premium increases were awarded to insurers for the last 10 years due to "inflationary pressures", and should have been accompanied by parallel HSP increases for precisely the same reason.

Concerns about awarding this overdue increase is very much a red herring given that the CPI catch-up increase we are requesting is estimated at less than a 1% (0.77%) increase in premiums translating into premium increase of approximately $1 per month.

PSG Consultation Questions

Determining Rates and Rate Reviews

1. If PSG rates are indexed (Option A), what should they be indexed to and why?

The rates (non-CAT and CAT) should be indexed by applying a calculated cost of living adjustment since 2014 as illustrated in the attached chart at the end of this submission. Note that these calculations are dated March 2024. It is vital that FSRA ensure any calculation is updated to date of revised guideline implementation and that it be and applied to all claims at implementation.

Our rationale is multi-pronged.

Alignment with Market Rates

Our businesses, employees, contractors and the infrastructure (commercial leases, energy, equipment, fuel costs etc.) required to support our practices have been subject to the same cost of living increases as the general population. Arguably, these pressures have been even greater in our sector. As we've written to FSRA in the past, we paid a particularly heavy price in the pandemic. This lost ground has not been reclaimed.

Increasing Scarcity of Human Resources

As outlined in our introductory remarks HSPs in this and all healthcare sectors are faced with increasingly scarce human resources resulting in constrained capacity resulting in delayed access to treatment. The following table reflects the growth in rehabilitation RHP along with supply per 1,000:

Discipline	Annual growth rate 2014-2022	Supply per 1,000 population
Nurses	1.5%	12
Occupational Therapists	3.3%	<1
Physiotherapists	3.8%	<1
Speech Language Pathology	2.5%	<1
Social Work	3.1%	<1

Source: Canadian Institute for Health Information (CIHI)

It is important to note that the rehabilitation professionals listed in the table are not quickly replaced when they retire or move into non-practicing roles (management, teaching, etc.). As all rehabilitation professionals are masters-level the education period is at least 5-6 years. The supply of these professionals is dependent on the availability of university places which are not currently sufficient to meet demographic trends. Statistics Canada data shows that since 2014 Ontario's population has grown by 18.6% and that the 65+ population grew by 40%. This led to demand for healthcare professionals which outstrips supply by an average factor of 5:1.

For a closer-to-the-ground look at the issue we offer this example from an ORA member company providing services in the Central East region reports:

ORA Member Company Experience:

Unbelievably, we now have a waitlist for newly referred clients.
I cannot hire OTs to work with these [serious and catastrophically injured] claimants because of a combination of lower pay (due to lower fees) and very difficult work (these client's are complicated and have often multiple injuries that are among the most difficult to treat – chronic pain, brain injury, etc). So, our clients need to wait for treatment.

I am always looking for good OTs to join us, and when I have made an offer and it is declined, I always ask why. These factors (low pay, difficult work) are usually cited, along with reports of long hours outside of the usual 9-to-5, and unpaid work time. Apparently, unlike ours, some companies do not, for example, pay for travel time.

This is a huge problem related to the relatively low pay we can afford in the auto (private) sector, when publicly funded OT employers (Corrections Canada, Veterans Affairs Canada, hospitals, etc.) are offering very appealing packages with excellent pay. For example, Corrections Canada has a starting salary of over $100,000/year, and no experience necessary. Auto insurance caps on funding in the 2014 PSG is completely out of date.

2. If PSG are moved to flat rates (Option B), how should those flat rates be determined and why?

We do not believe flat rates are viable. Serious injuries are by nature complex and rehabilitation programs are subject to an almost infinite number of demographic variables.

Generally speaking, all professional services are subject to various levels of complexity, the time required to provide treatment, and that expertise in one area of treatment may not translate into expertise in another area. We are unable to understand how flat rates could take these variables into account. Further, how quickly could flat rates adapt to changes in the market re increased costs and the needs of the injured claimant? A one-size fits all approach will not work or support the objective of care and service provision.

3. Should rate increases (Option A or Option B) be staggered incrementally over a few years, or should it take place at once?

It should take place at once. Our capacity to recruit and retain staff at below market rates is no longer a tenable option.

4. Should FSRA review fees regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Rates should be regularly and annually reviewed.

5. For Option C (Do Not Prescribe Rates) how often should insurers/HSPs meet to review/set maximum rates?

We do not consider Option C to be tenable.

It is FSRA's job to ensure that rates are fair and protect consumers. Moreover, insurers will no doubt emphasize cost issues over the provision of adequate supply of HSPs and claimants' care as they have shareholders' interests that they must take into account. This is consistent with insurer practice in relation to attendant care hourly rates. They continually use the hourly rates in the attendant care guideline to not only calculate the amount of the AC benefit but they also take the position that those hourly rates are the maximum that HSPs can be paid for their services - which is incorrect. Given this, FSRA should fully appreciate that insurers will not pay above the PSG given their track record on AC hourly rates.

We would like the regulator to remind insurers that they have a responsibility to play their part in ensuring that they have a role to play in keeping costs down. If the objective of the guidelines is to maintain care and ensure the availability of services then costs on the HSP side cannot be the only factor that FSRA should look at. Insurers must also take responsibility to mitigate their costs in the context of increasing PSG and AC hourly rates.

Specifically, insurers should be asked to demonstrate to FSRA that they:

- Conduct ongoing reviews of their operations with the goal of improving efficiencies in their companies so as to offset any increases in hourly rates
- Have cut red tape in their claims processes
- Have reduced administrative burdens in how claims are adjusted

Insurers should not rely upon egregious and escalating denial trends as a way of reducing their costs. Rather, they should provide FSRA with the steps they have taken to reduce unnecessary costs. Without such a mechanism there is little consumer-centred focus in a scheme that deems it reasonable to keep HSP rates depressed when the consequences are as we've described in this submission.

Other Considerations

6. Are there other options/considerations related to rates/fees that should be considered for the PSG?

Revise Language to Reduce Disputes, Improve Access

The PSG as written has multiple references and headings indicating that these are maximum rates. One line on p.2 notes “Insurers are not prohibited from paying above any maximum amount or hourly rate established in the Guideline.” This is the only such reference yet it carries considerable weight.

Multiple times in the years subsequent to the last increase to the PSG, in response to our requests to FSRA and the Ministry of Finance for a rate review, we have been told that despite the express language in the Guideline there is nothing in the regulation to prohibit insurers from paying more than the listed rates.

Why then use the language of “maximum"?

As the discussion paper outlines in its recap of feedback, HSPs report this to be a rare occurrence. As we discuss later in this submission *(see Rate Based Denials)* the ORA has narrative and quantitative (attached to this submission) data that illustrates insurer unwillingness to pay above PSG rates. Claimants' access to care has been increasingly compromised by an escalation in rate-related disputes.

Changes to the PSG must be accompanied by clarification that the listed rates stated are minimum hourly rates. Without this change any alteration in the rate will be subject to unnecessary uncertainty on the part of all stakeholders and give rise to further dispute.

Recommendations

1. References to ‘maximum’ must be removed from the Guideline.
2. Revise the Guideline to clarify that stated rates are minimums.
3. Make the PSG inclusive, updating to include professional groups who wish to be included and who are routinely involved in post accident assessment and treatment.

4. FSRA should issue guidance reinforcing automatic application of interest to overdue payments. Currently, interest is rarely paid despite the requirement to do so. This presents yet a further “cost of doing business" for HSPs as their administrative staff routinely chase insurers for interest payments

5. Reinstate mileage reimbursement.

    - In rural areas the lack of mileage benefit is a disincentive for the health care provider. This results in inequitable treatment compared to more urban areas in which the HSP does not need to drive as far and incur those associated costs

    - Additionally, there are many urban areas that are under serviced due to lack of HSP's (Windsor, Sarnia for example in SW Ontario) that require anywhere from 2-4 hours round trip by the HSP. Mileage is a significant cost to the rehab firm that should be reimbursed.

7. Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?

Yes.

Waitlists

As described earlier in this submission, HSPs in this sector are increasingly having to decline new referrals or establish and/or lengthen wait lists for service.

Impact of Denials on Compensation

Brokerage, Travel, Etc

Denials and partial denials have long been a feature of this sector. Beginning roughly around the time of the pandemic, HSPs began experiencing a significant increase of denials of all kinds with a very noticeable uptick in denials for payment of professional services such as planning, brokerage/communication and travel time related to client care.

This trend is illustrated by March 2021 findings of a survey conducted by the ORA, attached at the end of this submission.

Data was collected from 94 respondents including companies of various sizes and individual clinician/sole practitioners.

Key findings:

- 50% reported an increase in denials of travel time.
- 32% stated that increases in travel time denials were due to the dismissal of clinician recommendations (the OCF-18s) by insurers' maintaining that in-person visits are not required.
- 63% reported an increase in denial for planning time.(7.SF.12)
- 49% reported an increase in denials for preparation time. (7.SF.13)
- 42% reported an increase in brokerage time denials.(7.SF.15)

These sorts of denials, which have continued to escalate in the intervening years, are not unrelated to the issue of PSG rates. When HSPs are not paid for all the aspects of treatment required by their professional Colleges they still complete work free of charge, thereby further compressing their effective hourly compensation.

We share this ORA member's report, below, by way of further illustration.

ORA Member Experience: Physiotherapy and Registered Massage Therapy Provider with Multiple Locations

The numbers below represent the percentage of denials we received from January to mid-November 2024

- Location 1 - 29% of the total treatment plan values submitted were denied.
- Location 2 - 26% of the total treatment plan values submitted were denied.
- Location 3 - 22% of the total treatment plan values submitted were denied

I think the easiest way to look at the data is to highlight the most common reason for either partial approval or no approval on an Ocf 18.

By far the most commonly cited reason for not approving a line item or multiple line items on a treatment plan is "Not reasonable and necessary".

> I can tell you unequivocally, 5-10 years ago we would never get this type of response in these numbers.
>
> I can't for the life of me understand how an insurance adjuster has the training or knowledge to decide what is reasonable and necessary. I'm trying to get clarification on when adjusters need to send for an IE and I can't find the details in the SABS. Essentially, these denials are being poured into IE's or the LAT. This presents a number of problems.
>
> First, trying to provide appropriate and comprehensive treatment for our clients is challenging when we're getting denials of this magnitude. The therapists become disenfranchised with the one -sided nature of the process and are less likely to take these clients on if they can't provide appropriate care. Secondly, this inevitably sets up an adversarial situation and the client feels they are being railroaded by the insurance company on treatment they feel they need. Lastly, while some of the line item denials we might be able to work around when adjusters are denying something like team communication, this is an issue. Not being able to have a call or email with any other team members just makes the client's rehab less efficient and more costly in the end.
>
> Another example we run into is seeing clients that are still in hospital. We often get referrals to help clients in acute care and slow-stream rehab get the proper frequency of treatment they need. Often, adjusters will deny the parking costs citing we don't approve "administrative items that are the cost of doing business". This is absurd. Therapists can't be expected to shell out $20 out of pocket to see someone in a hospital if they're not getting reimbursed.

The opportunity costs in our sector of having a high percentage of treatment plans denied is a further considerable drain. HSPs contribute professional time to create an OCF 18 treatment plan and once denied there is no compensation.

Rate Based Denials

In 2023 the ORA undertook a pilot project in order to demonstrate to FSRA that insurers are routinely unwilling to pay above the PSG. Our findings demonstrated what we had long believed was the case. Namely, that insurers were generally unwilling to pay above the rates and that HSP requests for higher rates led to denials and delayed access to treatment for claimants.

This trend, as with all denials, has escalated.

We share this ORA member's report by way of further illustration.

> **ORA Member Experience: Occupational Therapy Service Provider in Central East Region**
>
> *I did a quick review of the OCF-18s submitted over the last 6 months and found that of all treatment plans submitted, we received the following responses:*
>
> - *Approved: 26.4%*
> - *Partial approvals: 45.3% (the denied items on these were our fee – they reduced it by 1/3 – and/or and indirect service time)*
> - *Denials: 28.3%*
>
> *These denials and partial approvals are insurance adjusters arbitrarily blocking claimant access to Regulated Health Professional recommended care. The partial approvals do not have to go to IE, and stand with no recourse for complaint, even though they amount to treatment denials. We do not work at $99.75/hr, so unless the client agrees to pay us the difference, which is rarely possible, we cannot proceed.*

8. What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

With respect to Option A, the only option we are supporting, we see few if any obstacles to prompt (30 - 60 days) implementation on the provider side. CPI adjustments were routinely provided by FSCO prior to 2014 with no implementation challenges.

At a higher public policy level we strongly encourage FSRA and the Ministry of Finance to update the Accident Benefit limits to mitigate the impact of higher HSP rates on claimants.

9. How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

We expect that FSRA's usual communication channels to insurers and HSPs, along with industry newsletters such as HCAI registrant list, 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.

10.Are there other considerations which have been missed that should be taken into account as part of the PSG review?

- Signing of OCF-18s as the Healthcare Practitioner updated to include Registered Nurses, Registered Massage Therapists, Registered Dietitians, and all other regulated healthcare providers, responsible for their own scope and standards of practice under their regulatory College / RHPA?, other? and involved in post-MVA client care

- $2,000 assessment cap and $200 form completion fee should be adjusted in parallel with PSG rates; language should be revised to confirm these to be minimum, not maximum rates payable.

Introduction to Attendant Care Hourly Rate Guideline Section

While we are gratified that this long overdue review of Attendant Care rates is taking place, the options presented in the consultation document do not reflect the significant changes demanded by today's realities. Below we offer observations and recommendations that address these.

Recommendation 1: Align with Market Rates

Payment rates for Attendant Care must be aligned with market rates. We suggest using the hourly rate paid by Ontario Health at Home for PSW services as a benchmark and index accordingly. Achieving a competitive market rate will allow for the retention and hiring of PSWs with the skill and experience level required by today's users of attendant care services following auto accidents. These are not clients whose needs are best served by new grads of fast-tracked PSW training. The need for skilled and experienced PSWs to work with the seriously injured is set within a highly competitive context, as excerpted below, from a February 2024 report the Canadian Institute for Health Information

> "*Surges in health care job vacancies (doubling since the start of the pandemic to 120,140 in 2022–2023) suggest that demand for health care is outpacing the gains in supply. Job vacancies for personal support workers (30,800 vacant positions; 25.7% of all health care vacancies)"*

Recommendation 2: Unified Rate for Invoicing and Payment

As outlined in our submission on HCAI, payment for all levels of care as broken down in the Form 1 must be made at a unified market rate. All levels of care on the Form 1 should continue to represent the care provided by the PSW and/or caregiver including healthcare and hygiene functions delegated by a RHP. Whereas the complex health/care and hygiene function is a controlled act under the RHPA, and requires training, education, delegation, intervention and/or ongoing supervision of the PSW/caregiver by an RHP (e.g. Registered Nurse, Respiratory Therapist etc.) the RHP services will be invoiced as part of the PSG on an OCF 18.

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 Case Managers, Occupational Therapists (who generally complete Form 1s) and Attendant Care providers to that project.

Recommendation 3: Divorce Form 1 Calculations 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.

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.

For many years it was understood, and clarified in a FSCO bulletin, that the detailed calculations within the Form 1 were intended to provide a total amount or quantum of the monthly amount payable. Historically, it was not the practice to expect providers, nor expectation

of the regulator or insurers, to bill in detailed line-by-line relationship to the interior values in the Form.

This changed radically, and without regulatory intervention, in 20– following a LAT decision that gave rise to insurers adopting the 'line-by-line' invoicing expectation creating financial and administrative hardship that compromised client care. Correcting this disconnect is vital.

Consultation Questions

Determining Rates and Rate Reviews

1. How should Level 1 and 3 (Option B) attendant care rates be indexed?

The indexed rates proposed in this consultation fall short of the market rate adjustment needed, as outlined above. If the regulator chooses to update the Attendant Care Rates through the indexation approach as outlined, this should be used for calculation only, with payments made at market rates.

2. Should Level 1 and 3 rate increases (Option B) be staggered incrementally over a few years, or should it take place at once?

It should take place at once. Our capacity to deliver appropriate care at below market rates is no longer a tenable option.

3. Should FSRA review the rates of all three Levels regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

As noted above we propose the establishment of a unified rate benchmarked to the rates paid for PSW by Ontario Health at Home and indexed in tandem with that rate. Otherwise, as with the PSG and other specified rates indexing should occur annually in order to avoid a situation such as the one our sector now finds itself in.

Other Considerations

4. Are there other options/considerations related to rates/fees that should be considered for the ACHRG?

- The current monthly allowance limits of $3, 000 non-CAT and $6,000 should be increased to align with increased hourly PSW rates and with indexing of the same going forward.
- All levels of care on the Form 1 should continue to represent the care provided by the PSW and/or family/caregiver, including healthcare and hygiene functions delegated by a RHP.
- Registered Nursing services for complex health/care and hygiene functions on the Form 1 that are a controlled act under the RHPA3, and require training, education, delegation, intervention and/or ongoing supervision of the PSW/family/caregiver by the Registered Nurse, will be invoiced as part of the PSG on an OCF 18. (Example controlled act: injections, bowel/bladder care, trach care, etc.)

5. Do you have any evidence that consumers are having difficulty in obtaining the attendant care they need (Level 1-routine personal care and Level 3-complex health/care)?

The distinction made in this question between the levels illustrates the disconnect between this current guideline and the realties outlined above. PSW companies cannot hire, assign or compensate staff with respect to providing distinct levels of care.

Yes. Attendant care providers report extraordinary difficulty retaining and recruiting experienced PSWs. The PSW shortage is well documented. Providers in this sector are unable to compete with other payer systems, particularly long term care and Ontario Health at Home.

We wonder if there might be data at FSRA that indicates how many claimants have approved Attendant Care benefits, but are not accessing this benefit likely due in part to the lack of competitive rates for PSW's. Further, we would be interested to know what cost savings this represents for insurers on an annual basis.

6. What are the key implementation considerations that should be taken into account for each option (i.e. timing, updates to billing systems etc.)?

We see few if any obstacles to prompt (30 - 60 days) implementation on the provider side.

At a higher public policy level we strongly encourage FSRA and the Ministry of Finance to update the monthly attendant care allowance levels to mitigate the impact of higher AC rates on claimants.

7. How can FSRA help to ensure that any changes to the ACHRGs are communicated to HSPs, insurers, consumers and other stakeholders?

Vigorous and clear communication with insurers is vital to implementing the changes we propose. Insurers in turn must create and communicate policies that provide adjusters with clear direction.

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.

8. Are there other considerations which have been missed that should be taken into account as part of the ACHRG review?

Again, there is a need for further stakeholder consultation to ensure that FSRA has heard the various arguments, has indeed taken them into account and educate FSRA on the implications of its recommendations to the Minister.

MIG Consultation Questions

Introduction

Though examining Minor Injury Guideline (MIG) rates along with others is vital, we are compelled to take this opportunity to address a significant challenge presented by what can only be a willful misunderstanding of the MIG by insurers compounded by FSRA's unwillingness to

intervene and support the rights of consumers to fair treatment by insurers and access to necessary and appropriate rehabilitation.

HSPs routinely battle insurers on behalf of claimants to leave the MIG and receive concussion/mTBI care. These clients should not have been in the MIG in the first place. It's been our experience that all insurance companies now insist claimants enter the MIG, even when they have a physician-diagnosed and documented concussion, suggesting HSP that they will be sent for an IE if the clinician does not put them in the MIG. This is problematic for a number of reasons:

- It sets up a relationship framed by distrust, causing claimants and HSPs to question the intentions of the insurance company from the outset of the claim.
- It is much harder to get out of the MIG once in and to get an OCF 18 approved, even when it can demonstrated that additional care is needed
- It inevitably leads to delays in care that can be months long, waiting for redundant and inappropriate IEs when it is well established that best practice around concussion is to start treatment early.

The result is delayed recoveries, disenfranchised clients and health care providers frustrated and exhausted by a system with rules easily flaunted by insurers, with no consequences.

Concussion can be a complex injury with layers of pain, emotional and psychological involvement. When the guidelines are blatantly disregarded, it does nothing but make an already challenging situation worse.

We understand that insurers have proposed including concussion/TBI in the MIG. Though the status quo, as described above, seems to enable this practice without a formal policy change we cannot stress enough that the MIG cannot adequately provide resources to treat the complex variety of conditions presented by concussions and traumatic brain injuries and FSRA must take steps to ensure claimants get the care they are insured for in a timely manner.

Determining Rates and Rate Reviews

1. If MIG rates are indexed (Option A), what should they be indexed to and why?

The rates should be indexed by applying a calculated cost of living adjustment since 2014. It is vital that FSRA ensure any calculation is updated to date of revised guideline implementation and that it be and applied to all claims at implementation. Our rationale for this increase is as has been provided earlier in this submission regarding the PSG and Attendant Care guidelines.

2. Should rate increases (Option A) be staggered incrementally over a few few years, or should it take place at once?

It should take place at once.

3. Is the existing block fee structure/amounts for pre-approved MIG treatment appropriate?Why or why not?

The current configuration of the block fees with an additional $1800 available after discharge from block care creates unnecessary obstacles to continuity of care. The requirement to submit an OCF-18 to access the remaining $1800 should be eliminated.

4. Should FSRA review MIG rates regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

As with the PSG and AC rates indexing should occur annually in order to avoid a situation such as the one our sector now finds itself in.

Other Considerations

5. Are there other options/considerations related to rates/fees that should be considered for the MIG?

Addressed above.

6. Do you have any evidence that consumers are having difficulty obtaining HSP care?

Please see the Introduction to this section for our response.

7. What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

Addressed above.

8. How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

Addressed above.

9. Are there other considerations which have been missed that should be taken into account as part of the MIG review?

Addressed above.

Conclusion

The Ontario Rehab Alliance is pleased to have this opportunity to provide our comments to FSRA on these matters of profound importance to Health Service Providers in the auto sector.

We would be pleased to offer any additional comments or respond to questions that arise from this submission and very much hope that we will have further opportunity to contribute to this consultation process prior to initiatives being recommended and/or adopted for implementation.

Sincerely,

Laurie Davis
Executive Director

MVA Rehab Road Conditions: HSP Survey

Laurie Davis, ORA

SEPTEMBER 21 2022

Respondents:

- Owners, managers, sole practitioners, clinicians

- Approx 25% each category: sole practitioner, 2-5 FTE, 6-15 FTE & 16 +

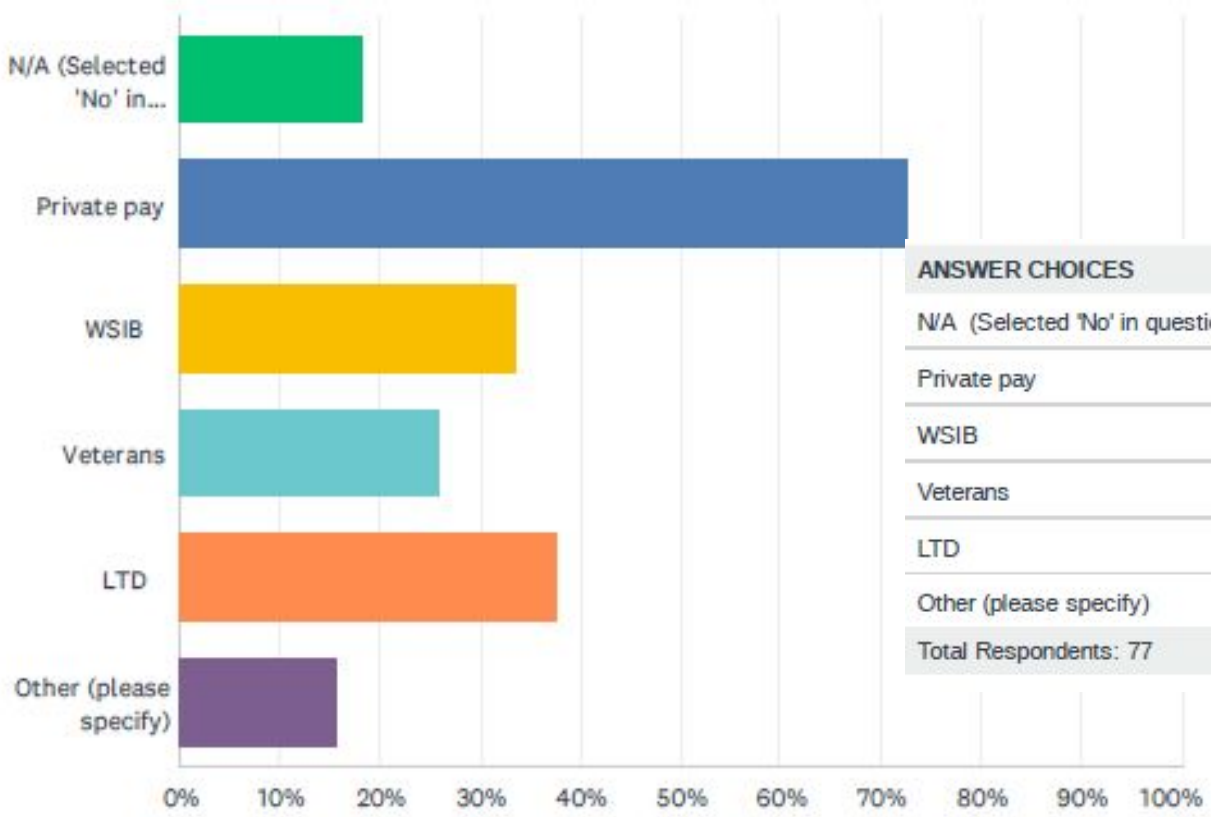
- 17 % clinic-based
- 39 % community
- 44 % combination

Respondents:

20+ disciplines and roles, some predominating:

- 39 % Physiotherapy
- 34 % Occupational Therapy
- 26 % Case Management
- 26 % Registered Massage Therapy
- 23 % Rehab Support
- 18 % Speech Language Pathology
- 15 % Psychotherapy
- 13% Psychology
- 9 % Personal Support
- 6 % Chiropractic

Payor systems/sectors with higher rates than MVA:



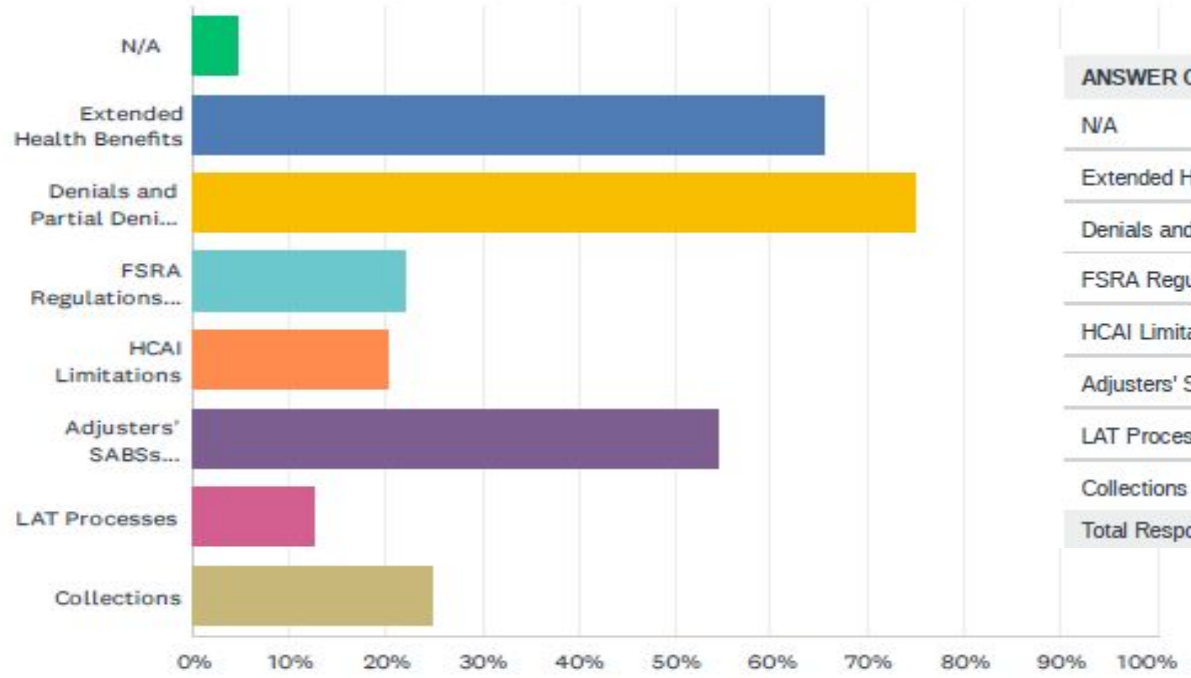
ANSWER CHOICES	RESPONSES	
N/A (Selected 'No' in question 5)	18.18%	14
Private pay	72.73%	56
WSIB	33.77%	26
Veterans	25.97%	20
LTD	37.66%	29
Other (please specify)	15.58%	12
Total Respondents: 77		

#	OTHER (PLEASE SPECIFY)
1	massage 95$ per hrs.
2	Employer
3	First Nations / NIHB
4	Self Pay rates
5	Some extended health insurers
6	private
7	Extended Health Insurers
8	tort
9	Med legal e.g. FCC
10	in certain cases WSIB complex care....
11	Auto mechanics $130/hr, Exotic Woods Shop rate $120/hr...
12	MVA is the poorest payer

All respondents agreed that there was more red tape with MVA and identified the three most troublesome aspects of MVA red tape:

Q8 If yes to question 7 - please identify the three aspects of red tape below that are the most troublesome.

Answered: 64 Skipped: 13

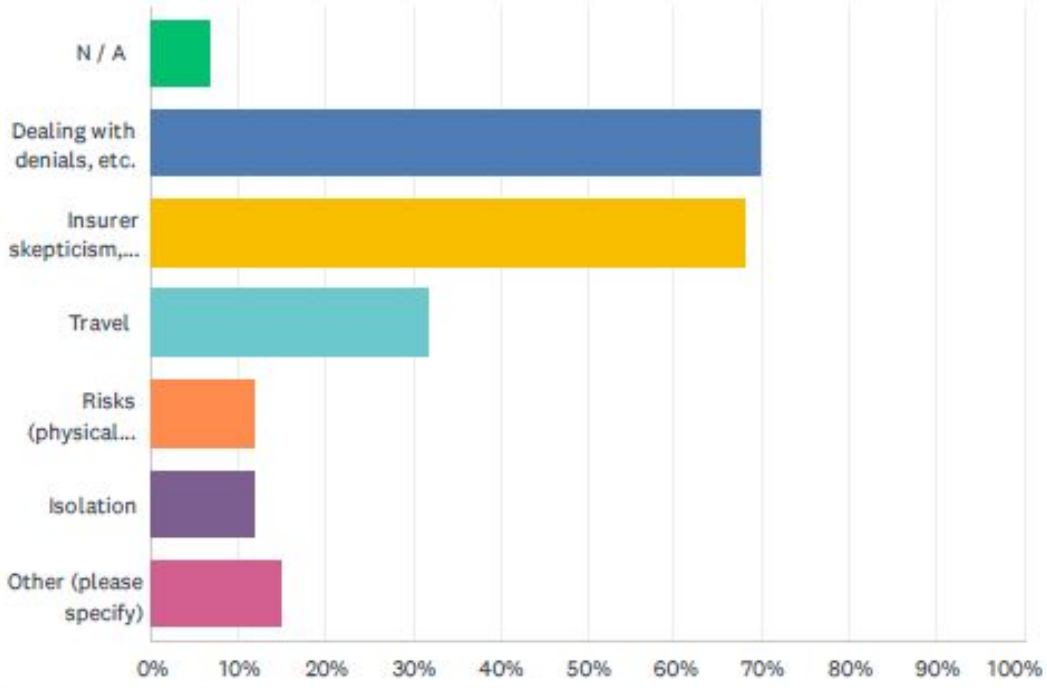


ANSWER CHOICES	RESPONSES
N/A	4.69%
Extended Health Benefits	65.63%
Denials and Partial Denials (of all kinds)	75.00%
FSRA Regulations (AIR, etc.)	21.88%
HCAI Limitations	20.31%
Adjusters' SABSs interpretations	54.69%
LAT Processes	12.50%
Collections	25.00%
Total Respondents: 64	

Respondents identified the factors in play with staff recruitment and retention difficulties:

	YES	NO	N / A	TOTAL	WEIGHTED AVERAGE
Better compensation (includ. not paying mileage, benefits, etc.) in other sectors.	56.90% 33	6.90% 4	36.21% 21	58	1.79
Better workings conditions in other sectors.	26.42% 14	28.30% 15	45.28% 24	53	2.19
Greater opportunities for advancement in other sectors.	37.04% 20	14.81% 8	48.15% 26	54	2.11
Greater opportunities for clinical education/mentoring.	25.00% 13	32.69% 17	42.31% 22	52	2.17
Less administrative burden.	53.45% 31	10.34% 6	36.21% 21	58	1.83

Respondents identified the MVA sector working conditions, that they feel are the most discouraging for staff:



ANSWER CHOICES	RESPONSES
N / A	6.67%
Dealing with denials, etc.	70.00%
Insurer skepticism, overriding clinical decisions and undervaluing clinical opinion	68.33%
Travel	31.67%
Risks (physical safety, contagion, abuse)	11.67%
Isolation	11.67%
Other (please specify)	15.00%
Total Respondents: 60	

#	OTHER (PLEASE SPECIFY)
1	The volatility and lack of consistency - treatment being suddenly stopped and started for various reasons - denials later overturned, running out of funds without warning, unexpected denials, delays, different adjusters having different practices and processes eg. hourly rate being reduced after working with the client at full rate, goods that one adjuster wants submitted via oct 21 and another wants submitted via oct 6 etc
2	administrative burden, Insurer denials, limits w treatment & need protected accounts for Non-Cat as a majority with tougher threshold for CAT
3	dealing with denials and partial approvals would be reasonable if the adjusters would respond in a timely way but the constant chasing and phoning/emailing repeatedly before getting a response is extremely time consuming
4	Travel is not the issue but unwillingness to pay mileage or travel costs is problematic when working in rural areas
5	Clients are typically more challenging than in other sectors.
6	Lawyers influencing patients
7	Payment delays, lack of response by adjusters, legal teams, difficulty with communication (telephone/email)
8	Lack of respect
9	Not being paid fairly due to rates

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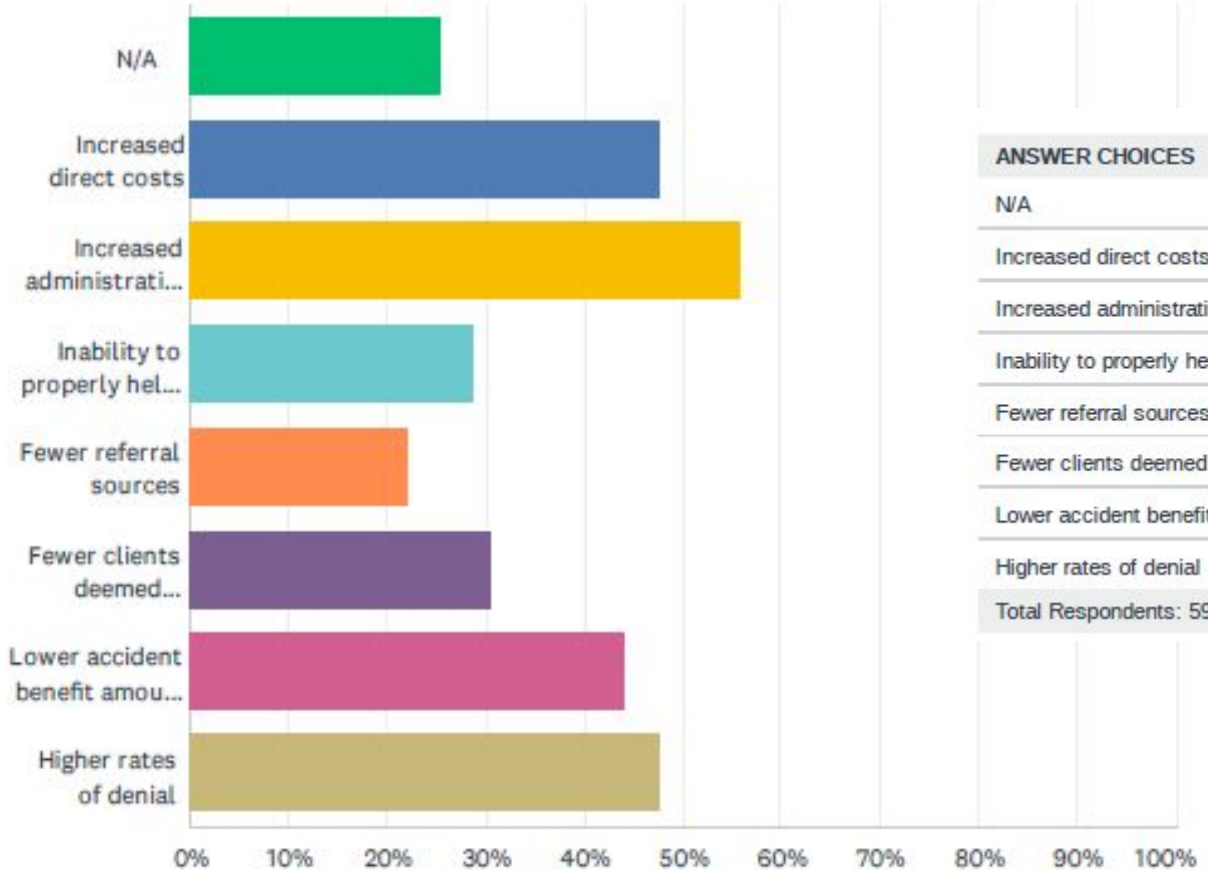
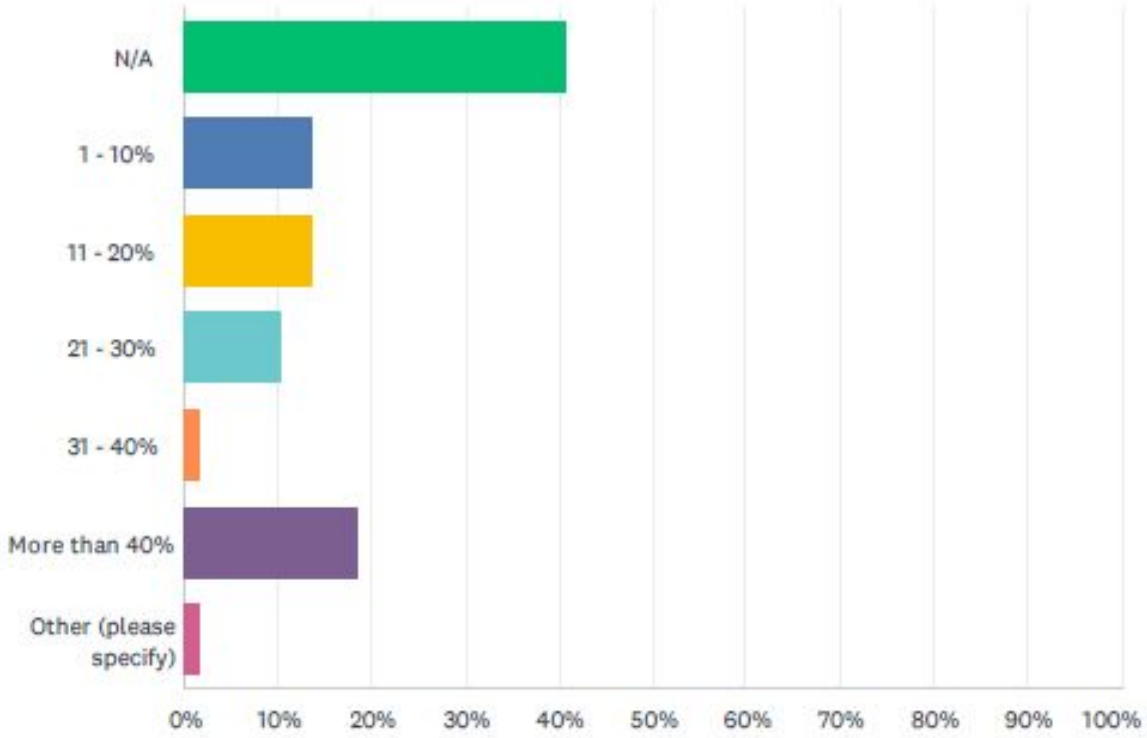
MVA Rehab Road Conditions: HSP Survey

Most respondents indicated that they were making plans to become less reliant on revenues from this sector and identified the factors contributing to this decision:



ANSWER CHOICES	RESPONSES
N/A	25.42%
Increased direct costs	47.46%
Increased administrative / indirect costs	55.93%
Inability to properly help clients	28.81%
Fewer referral sources	22.03%
Fewer clients deemed Catastrophic	30.51%
Lower accident benefit amounts available for non-CAT injuries	44.07%
Higher rates of denial	47.46%
Total Respondents: 59	

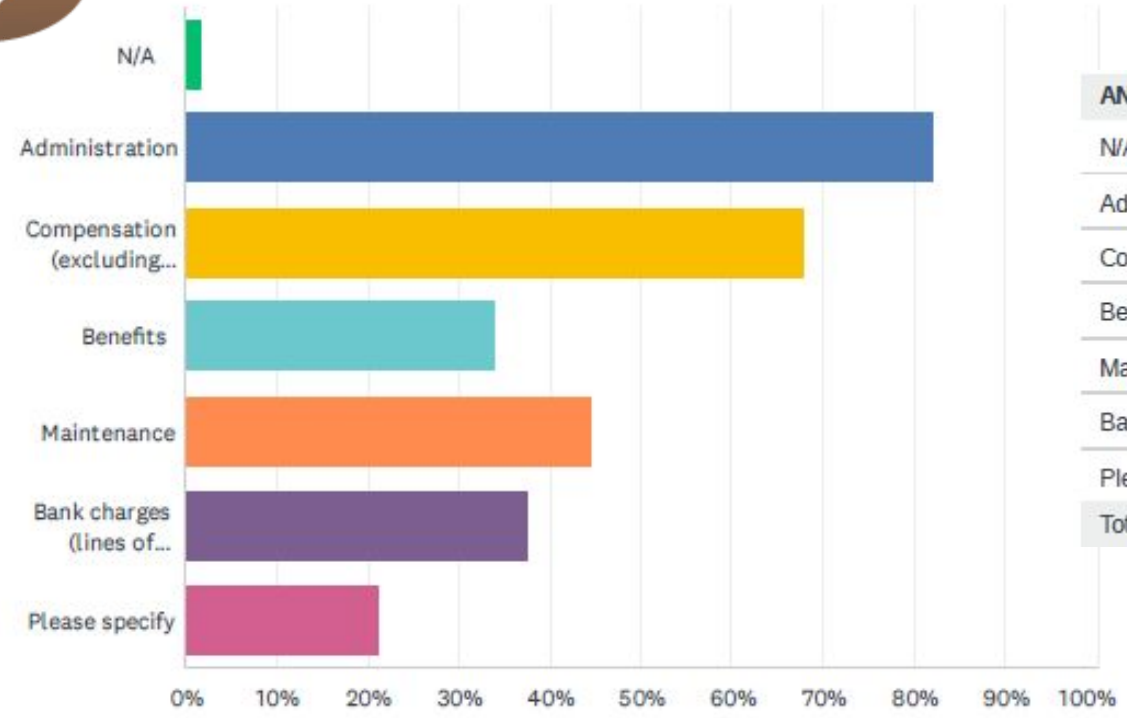
Respondents identified the percentage range decrease of revenues from MVA that best applies to their intention to reduce reliance on this sector:



ANSWER CHOICES	RESPONSES
N/A	40.68%
1 - 10%	13.56%
11 - 20%	13.56%
21 - 30%	10.17%
31 - 40%	1.69%
More than 40%	18.64%
Other (please specify)	1.69%
Total Respondents: 59	

#	OTHER (PLEASE SPECIFY)
1	This was done years ago when the reduction in auto insurance benefits had the most sweeping impact. We reduced our dependency on MVA industry revenue by more than 40%

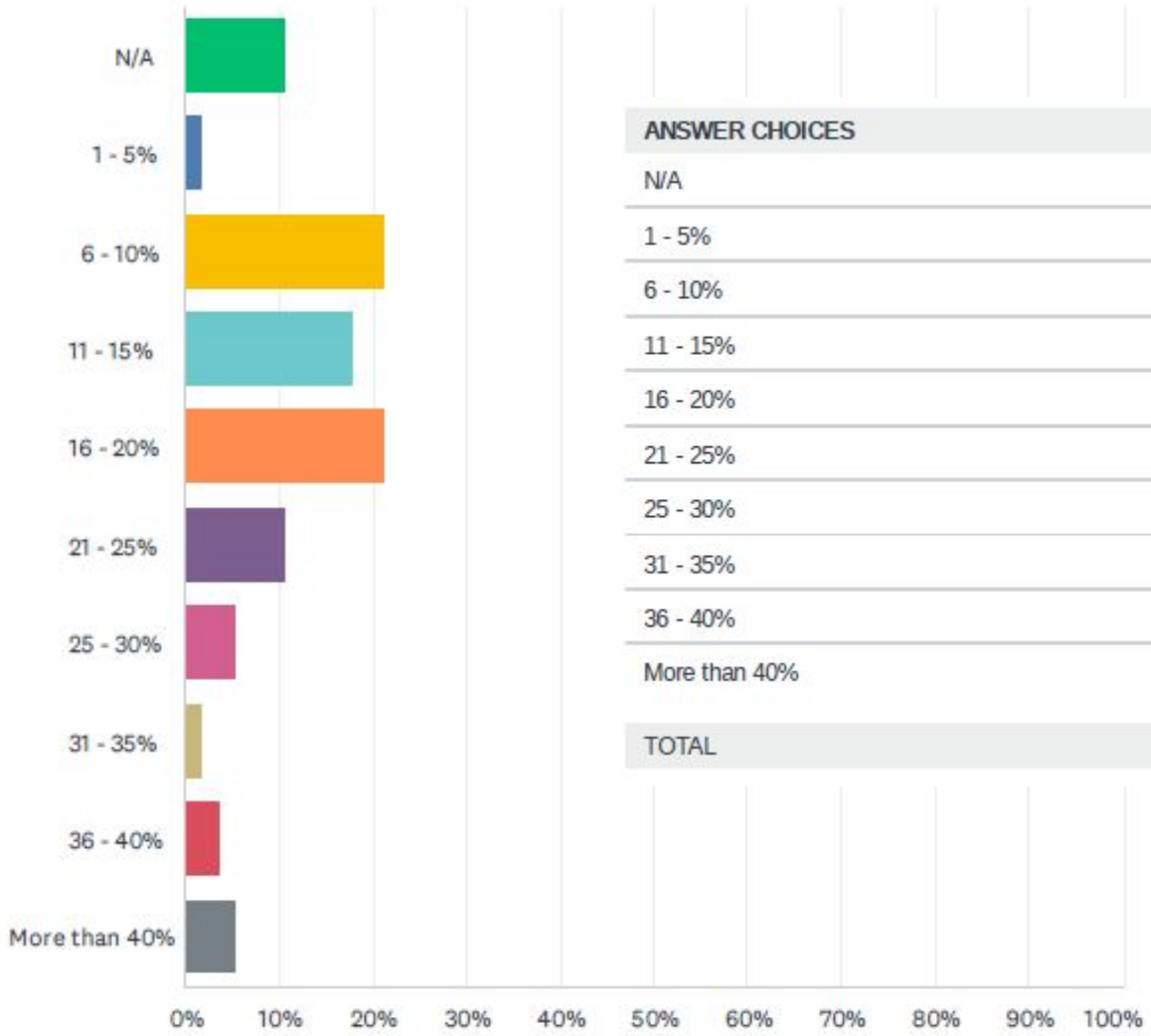
Respondents identified that operating costs have increased in the past ten years, and identified factors:



ANSWER CHOICES	RESPONSES
N/A	1.79%
Administration	82.14%
Compensation (excluding benefits)	67.86%
Benefits	33.93%
Maintenance	44.64%
Bank charges (lines of credit etc.)	37.50%
Please specify	21.43%
Total Respondents: 56	

#	PLEASE SPECIFY
1	Travel costs
2	Office rental
3	CYBER SECURITY
4	Inflation.
5	General office supplies
6	Travel Coats: fuel; vehicle repairs/maintenance
7	Mileage ppe
8	AIR filing
9	Costs of everything has risen significantly in hte past decade, rents, transportation, materials, machinery...
10	Bank Loans
11	All costs increased and rate of MVA reimbursement is poor with no increase
12	Cost of fuel

All but two respondents agreed that profit margins for work in this sector have declined, and estimated the percent decrease:



ANSWER CHOICES	RESPONSES	
N/A	10.71%	6
1 - 5%	1.79%	1
6 - 10%	21.43%	12
11 - 15%	17.86%	10
16 - 20%	21.43%	12
21 - 25%	10.71%	6
25 - 30%	5.36%	3
31 - 35%	1.79%	1
36 - 40%	3.57%	2
More than 40%	5.36%	3
TOTAL		56

March 2024

Professional Services Guideline (PSG) Rates based on Ontario CPI Index Increases 2015 – 2023 Non Cat & Cat Rates**

Years		Chiro	OT/PT/Pod	Psych	SLP	RN	Non Reg
2014	Non	112.81	99.75	149.61	112.22	91.43	58.19
	CAT	135.36	119.92	179.29	134.17	109.24	89.07
2015		114.50	101.24	151.85	113.90	92.80	59.06
		137.39	121.72	181.98	136.18	110.88	90.41
2016		117.13	103.57	155.34	116.52	94.94	60.42
		140.55	124.52	186.17	139.31	113.43	92.49
2017		119.71	105.85	158.76	119.08	97.02	61.75
		143.64	127.26	190.27	142.37	115.92	94.52
2018		123.42	109.13	163.68	122.77	100.03	63.66
		148.09	131.21	191.68	146.79	119.51	97.45
2019		126.50	111.86167.77	125.84	102.53	65.25	
		151.79	134.49	196.47	150.46	122.50	99.89
2020		127.64	112.87	169.28	126.97	103.45	65.84
		153.16	135.70	198.24	151.81	123.60	100.79
2021		133.77	118.29	177.41	133.06	108.42	69.00
		160.51	142.21	207.75	159.10	129.53	105.63
2022		146.75	129.76	194.62	145.97	118.94	75.70
		176.07	156.00	227.90	174.53	142.09	115.88
2023		155.26	137.29	205.91	154.44	125.88	80.09
		186.28	165.05	241.12	184.65	150.33	122.60

Ontario Consumer Price Index Increases per Statistica.com

2015 1.5%
2016 2.3%
2017 2.2%
2018 3.1%
2019 2.5%
2020 0.9%
2021 4.8%
2022 9.7%
2023 5.8%

No reference to Social Work rates as they are not part of PSG

Pursuit HEALTH MANAGEMENT

** excludes applicable HST

Ontario Rehab Alliance

Above-PSG Rates

Pilot Project

Health Service Provider Rate Tracking on Treatment Plans

May to November 2023

Background

Prior to the inception of the Financial Services Regulatory Authority (FSRA), when auto insurance was regulated by the Financial Services Commission of Ontario (FSCO), FSCO's Superintendent had responsibility for annually reviewing the Professional Services Guideline, (PSG), which sets out the rates payable by insurers to rehabilitation services for those injured in auto accidents.

The last such review took place in 2014. Despite frequent petitioning of FSRA by Health Service Providers (HSP), including the ORA, no subsequent review has since occurred. Instead, FSRA has advised the ORA and that the PSG does not, contrary to wording on the PSG's frequently referenced rates table, prevent insurers from paying above the PSG.

Providers of all disciplines over the last several years have struggled to get paid at higher-than-PSG rates in order to fairly compensate their staff and operate sustainable practices in the face of rising operating costs. Such attempts are rarely successful.

This pilot project was conceived and undertaken by Ontario Rehab Alliance members to demonstrate to FSRA what our day-to-day experience has led us to suppose: that almost all insurers treat PSG rates as maximums.

This document presents our findings.

Participating Providers Information

Provider Type	Number of Participants
Unregulated Providers (Non-Reg)	1
Occupational Therapists, Physiotherapists, Podiatrists (OT / PT / POD)	24
Regulated Nurses (RN)	1
Speech Language Pathologists (SLP)	10

Insurers

Allstate Insurance Company
Aviva Insurance Company
Belair Direct
CAA Insurance
Certas Home and Auto Insurance
Co-Operators General Insurance Company
COSECO Insurance Company
Gore Mutual Insurance
Guarantee Company of North America
Intact Insurance
TD General Insurance Company
TD Home and Auto Insurance
The Dominion of Canada General Insurance
The Personal Insurance Co.
Travelers Canada
Wawanesa Mutual Insurance Company
Zenith Insurance

Ontario Rehab Alliance

What happened when health services providers (HSPs) charged a sustainable and necessary rate on treatment plans?

Treatment Plan Approval Status	Total Number of Plans Per Adjuster Response
Approved	12
Partially Approved	23
Total Plans Submitted	***35***

a. **How often was a higher rate approved on treatment plans?**

The plans submitted at a higher rate were approved **34%** of the time.

b. **How often were the providers only approved at the PSG rates?**

The plans were Partially Approved with a rate adjustment equivalent to the PSG rates **66%** of the time.

Reasons Provided for Partial Approvals By Adjusters

The reasons provided by adjusters below, demonstrate that many insurers believe and treat the PSG rates as maximums and not negotiable.

Reasons were copied from the treatment plans into our pilot project tracking form, by our members.

- "Partially Approved based on current PSG rates"
- "Fee exceeds reasonable fee for good or service"
- "Fee exceeds maximum allowed" (noted 7 times)
- "Form fee reduced to 1 hr" (Cost to prepare form - $200, amt approved - $112.22)
- Reduction as per FSCO maximum catastrophic OT rate of $119.92

- The hourly rate has been reduced from $156 to $119,92 as this is the maximum hourly rate payable as per the Professional Services Fee Guideline.
- This plan has been partially approved as the fee's proposed are not reasonable, necessary & excessive. The maximum payable for 1hr of Occupational Therapy service is $119.92/hr as per the fee guidelines. I have approved this plan up to the maximum payable.
- As per the Professional Services Guideline -Superintendent's Guideline No. 03/14,the maximum hourly rate for Occupational Therapy services is $99.75
- Authorized amount exceeded (noted 3 times)
- Fee exceeds reasonable fee for good or service. Hourly rate for OT services is $99.75
- Fee exceeds maximum allowed. 15(2)(b) and 16(4)(a) of the Statutory Accident Benefits Schedule say expenses that exceed either the maximum rate or amount of expenses under the guidelines are not covered. The maximum rate for this recommendation is $99.75/hr.
- Fee exceeds reasonable fee for good or service
- Hourly Fees for Professional or Unregulated provider OT $119.92
- Length of Session and Hourly Fees Reduced 1 HR $99.75 (noted 2 times)
- Partially Approved based on current PSG rates
- Authorized amount exceeded noted on OCF 18- EOB attached states - Please note that the request exceeds the maximum hourly rate as set out by FSCO in the Professional Fee Guidelines for Physiotherapists and Speech-Language Pathologists.

Appendix

OCF Rates Submitted vs. Approval Amounts for Registered Nurses (RN)

Rates Submitted At	# of OCFs Submitted	Approval	Approved Rate	PSG Rate For Reference
RN – CAT - $142.09	1	Partially Approved	$109.24	$109.24

From the 1 treatment plan submitted by our Registered Nurse at a higher rate than noted in the PSG for a client identified with catastrophic impairments, it was partially approved at a reduced rate equivalent to the PSG.

OCF Rates Submitted vs. Approval Amounts for Occupational Therapists (OT), Physiotherapists (PT), Podiatrists (Pod)

Rates Submitted At:	# of OCFs Submitted:	Treatment Plan Approval:	Approved Tx Plan Rate	PSG Rate For Reference
CAT Rate - $156.00	2	Partially Approved	$119.92	$119.92
CAT Rate - $156.00	3	Approved		
Non-CAT Rate - $129.76	7	Approved		$99.75
Non-CAT Rate - $129.76	11	Partially Approved	$99.75	$99.75
Non-CAT Rate - $129.76	1	Partially Approved	$119.92	$99.75

Summary

From the 24 treatment plans submitted by our OTs/ PTs/ Pods at a higher rate than noted in the PSG, for clients identified with non-catastrophic impairments:

- 7 plans were approved at the higher rate;
- 11 plans were partially approved, with a reduced rate equivalent to that of the PSG;
- 1 plan was partially approved, with a reduced rate than submitted;

From the 5 treatment plans submitted by our OTs/ PTs/ Pods at a higher rate than what is noted in the PSG, for clients identified with catastrophic impairments:

- 2 plans were partially approved, with a reduced rate equivalent to that of the PSG;
- 3 plans were approved at the higher rate.

OCF Rates Submitted vs. Approval Amounts for Speech Language Pathologists (SLPs)

Rates Submitted At	**# of OCFs Submitted**	**Approval**	**Approved Tx Plan Rate**	**PSG Rate** For Reference
Clinic Hourly Rate For SLP - $150	3	Approved		$134.17
Clinic Hourly Rate for SLP - $150	4	Partially Approved	$112.22	$112.22
Clinic Hourly Rate for SLP - $150	1	Partially Approved	$134.17	$135.17
SLP – non cat - $145.97	1	Partially Approved	$112.22	$112.22

Summary

From the 10 treatment plans submitted by our SLPs at a higher rate than noted in the PSG, utilizing their clinics regular rate for SLP services:

- 3 plans were approved at the higher rate;
- 4 plans were partially approved, with a reduced rate equivalent to that of the non-CAT rate noted in the PSG;
- 1 plan was partially approved, with a reduced rate equivalent to that of the CAT rate noted in the PSG

For the 1 treatment plan submitted by our SLPs at a higher rate than noted in the PSG for clients with non-catastrophic impairments:

- It was partially approved at the suggested reduced rate equivalent to the PSG rate.

OCF Rates Submitted vs. Approval Amounts for an Unregulated Provider

Rates Submitted At	# of OCFs Submitted	Approval	Approved Rate	PSG Rate For Reference
Non Regulated - cat - $115.88	1	Partially Approved	$89.07	$89.07

For the 1 treatment plan submitted by an unregulated provider at a higher rate than noted in the PSG for a client with catastrophic impairments, it was partially approved at the reduced rate equivalent to that of the PSG.

About ORA

The ORA represents primarily small to medium sized healthcare businesses that collectively employ upwards of 4000 healthcare providers including Regulated Health Professionals from all disciplines, social workers, personal support, and rehabilitation support workers. We are the primary providers of rehabilitation to Ontarians seriously injured in automobile accidents. Most of our members work throughout the healthcare system, giving us a wide-angle view. We are the only association focused primarily on the interests and issues of health providers in the auto sector.

Our member companies operate in home, community, and clinic settings. As health professionals we have a strong duty of care to our clients, as business owners we have a responsibility to keep the business viable for ourselves, our staff, and the clients who depend on us.

On behalf of its members, the ORA advocates for motor vehicle accident victims, adequate insurance benefits, and fair treatment of those injured. We help members to navigate the claims system with timely information bulletins on new requirements and issues, and with resources to support daily operations.

We thank you for your time.

Please connect with Laurie Davis, Executive Director, for more information.

CONTACT

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Health Service Providers' Experience & Emergent Issues Survey
FINDINGS OVERVIEW

<table>
<tr><th colspan="2">INSURER-COMPROMISED CLIENT CARE
ENCROACHING ON CLINICIAN SCOPE
ARBITRARY DENIALS OF DIRECT AND INDIRECT TIME</th><th>INSURER-COMPROMISED EFFICIENCY</th></tr>
<tr><td>Planning, Preparation, Brokerage Denials</td><td>Travel Time Denials</td><td>Attendant Care:
Requests for Additional Info</td></tr>
<tr><td>42-63% of respondents reported increases in denials on planning, preparation and brokerage codes.

Increased denials for Reporting (7.SJ.30) and Form Preparation of OCF 18's also reported.</td><td>50% of all respondents experienced increase in denials of travel time.

32% of respondents state that increases in travel time denials are due to insurer forcing virtual visits.</td><td>40% of respondents noted that they were affected by requests for extraordinarily detailed "Attendant Care Plans" or timesheets.

This issue was reported only within Case Management, Occupational Therapy & multidisciplinary companies.</td></tr>
<tr><th colspan="3">HEALTHCARE PROVIDERS PAYING THE PANDEMIC PRICE</th></tr>
<tr><th>PPE</th><th>Changing Practices</th><th>Suffering Financially</th></tr>
<tr><td>0% of respondents reported that they billed insurers for their <u>staff's</u> PPE on treatment plans.

Only 3% of respondents reported having regularly billed for PPE used by their <u>clients</u>. Insurers reimbursed them on an 'occasional' or 'rare' basis.</td><td>HSPs report increased costs of doing business against decreased earnings.

Requirements of indirect time have grown while insurers increasing deny costs of indirect time spent for client treatment.

Providers facing decreased referral volumes, loss of staff.</td><td>83% of all respondents experienced a decline in revenue and had to change/ adapt their services due to the pandemic.

Greatest number of responses noted reduction in revenue between 25-50%.

OT, SLP & Case Management are the hardest hit specialties.</td></tr>
</table>

Respondent Overview

- 110 total responses
  - 16 respondents disqualified (duplicates, inadequate identifiers, no responses)
- 94 accepted responses
  - 30 – on behalf of a company as a whole (multidisciplinary)
  - 64 - individual clinician/sole practitioner responses
- 79 companies represented.

Methodology

The survey was developed by the Ontario Rehab Alliance (ORA) with significant input from the Ontario Society of Occupation Therapists (OSOT). It was distributed by these associations along with Ontario Society of Speech Language Pathologists and Audiologists (OSLA). Additionally, the ORA distributed it through its non-member newsletter. Respondents were directed to complete the survey only if they worked in the auto sector. Individual and company names were requested to ensure the integrity of the data. Responses were collected over a 10- 14-day period in March 2021.

Data was separated by individual clinician responses and responses submitted on behalf of multidisciplinary companies that offer multiple disciplines.

If there were few responses in a clinician category they were not included as representative of their discipline; these are included in overall totals.

Individual profession responses include: Case Management, Occupational Therapy, Physiotherapy, Speech Language Pathology, Psychology, Psychotherapy, Registered Massage Therapy, Chiropractic, Social Work, Rehab Support, Kinesiology, Registered Dieticians & Audiology.

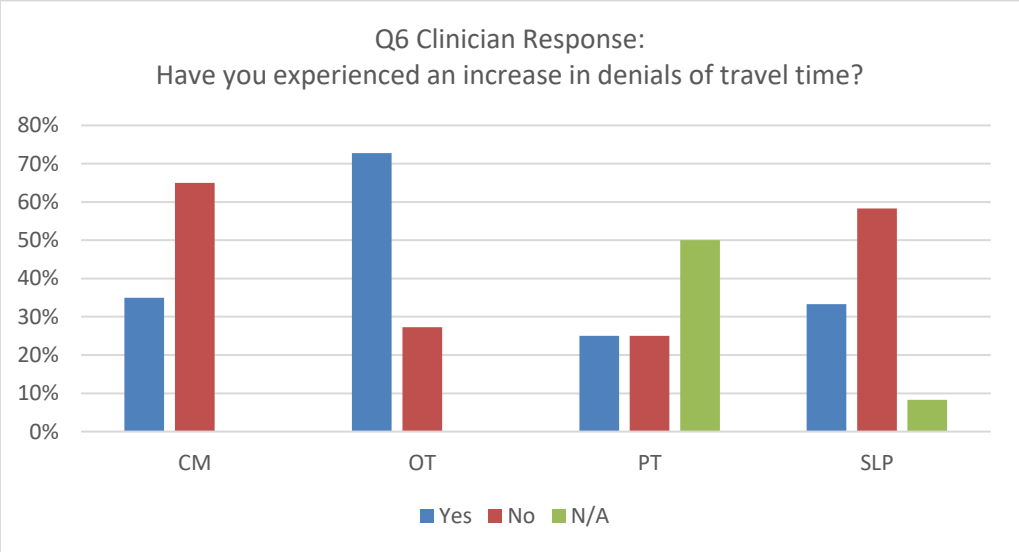
Less frequently represented professions (Kinesiology, R. Dieticians and Audiologists) are grouped into "Other" category for clinicians.

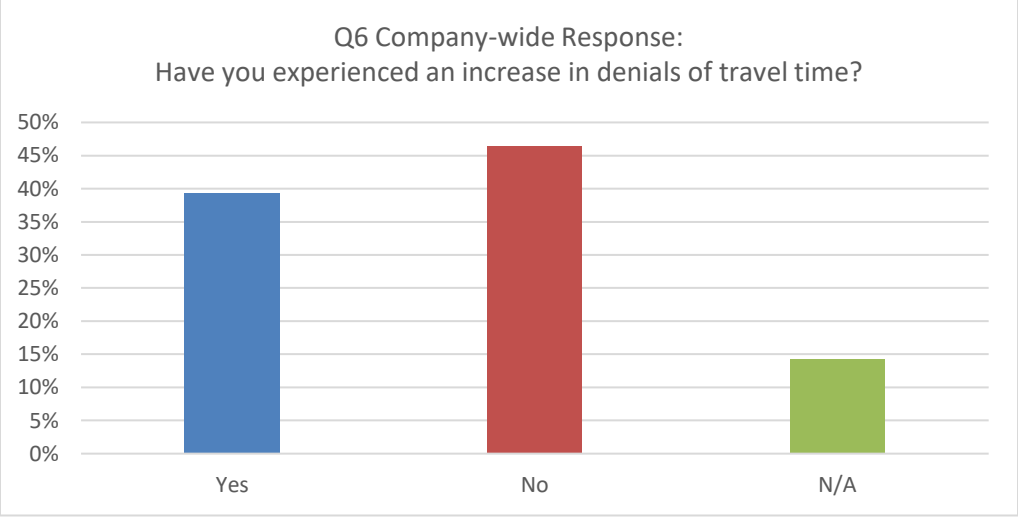
The 'drill down' data below supports the key findings outlined in the overview chart above.

Q6. Have you experienced an increase in denials of travel time?

50% of respondents experienced increase in denials of travel time.
32% of respondents stated that increases in travel time denials were due to the dismissal of clinician recommendations (the OCF-18s) by insurers' maintaining that in-person visits are not required.

A number of clinicians commented that insurers are denying travel time and claiming that it is the "cost of doing business" or belongs under "overhead costs".





Q14. Have you experienced an increase in denials of payment for the following activities with the insurer rationale being that such activities "are a cost of doing business"?

Planning (7.SF.12) 63% of respondents experienced an increase in denial for planning time.

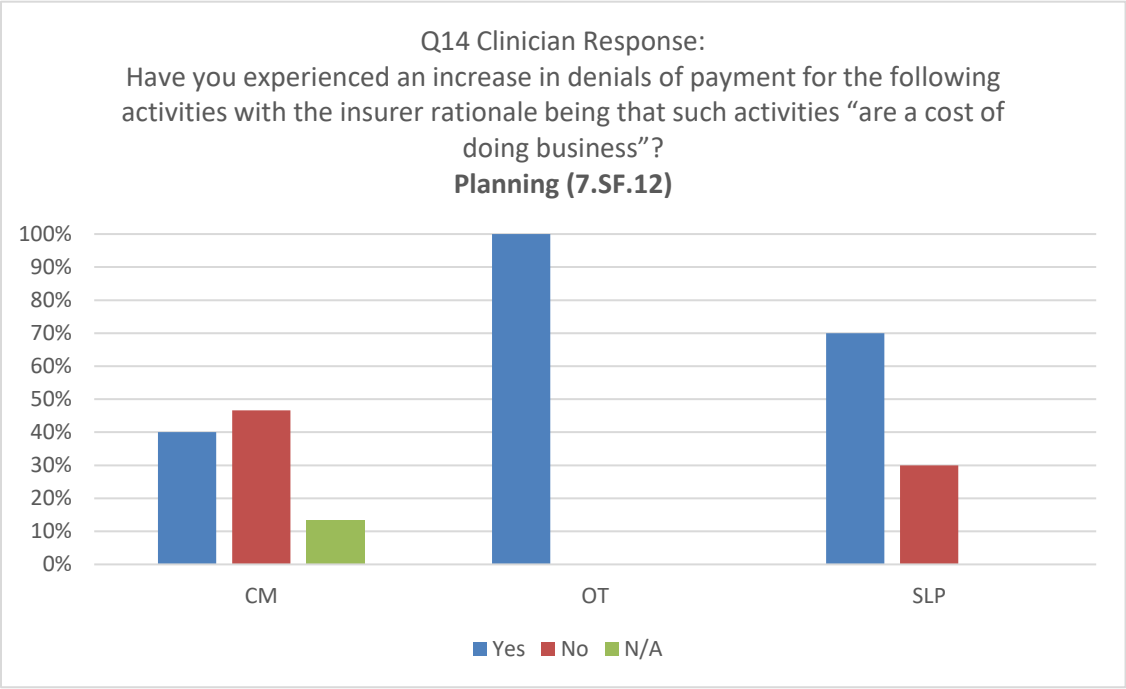
Preparation (7.SF.13) 49% of respondents experienced an increase in denials for preparation time.

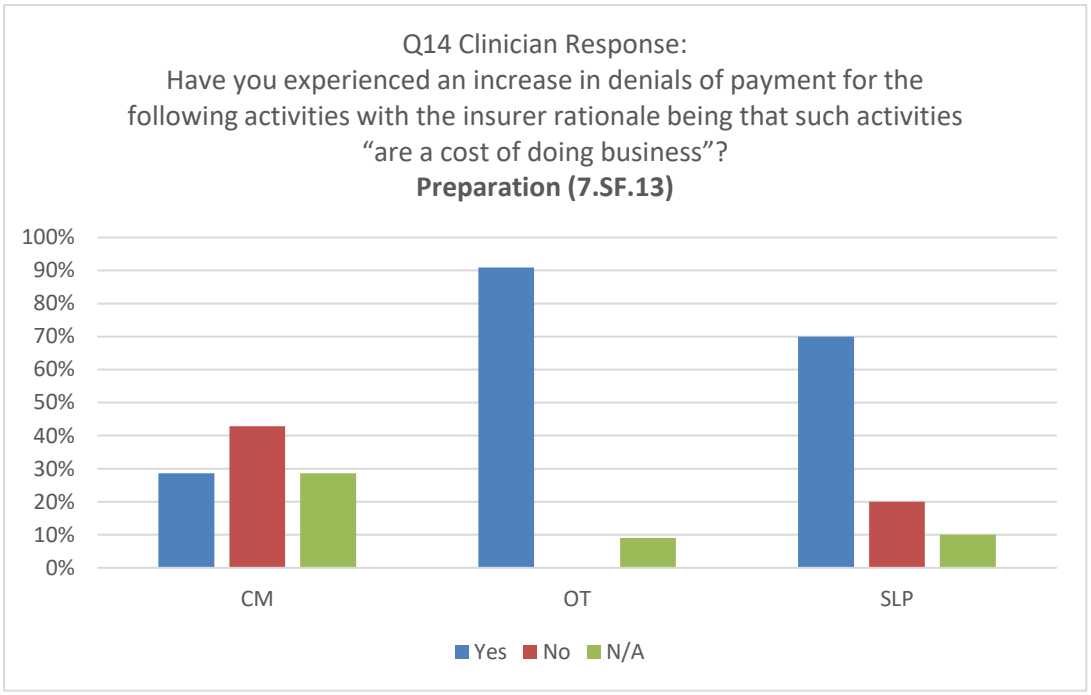
Brokerage (7.SF.15) 42% of respondents experienced an increase in brokerage time denials.

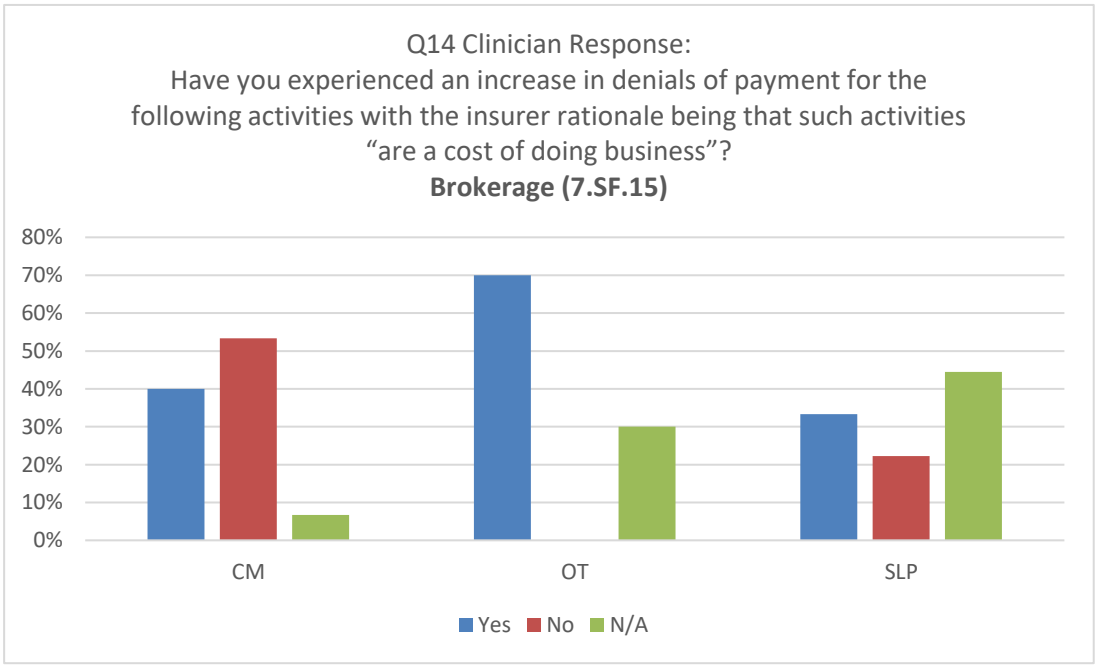
The highest rates of denial were reported for Case Management (CM) & Occupational Therapy (OT) and Speech Language Pathology (SLP).

Comments related to this question also indicated an increase in denials for Reporting (7.SJ.30) and for Form Preparation (OCF 18's).

A number of respondents also indicated in comments that they no longer bill for indirect time for the activities listed here having found that dealing with insurers on these items is not worth the extra time and trouble it takes to be compensated for these services. Some have stated that it is too time-consuming to submit a complaint to the insurer, the insurance ombudsman and FRSA in stages OR wait for a LAT decision on these matters; consequently, they simply don't bother.



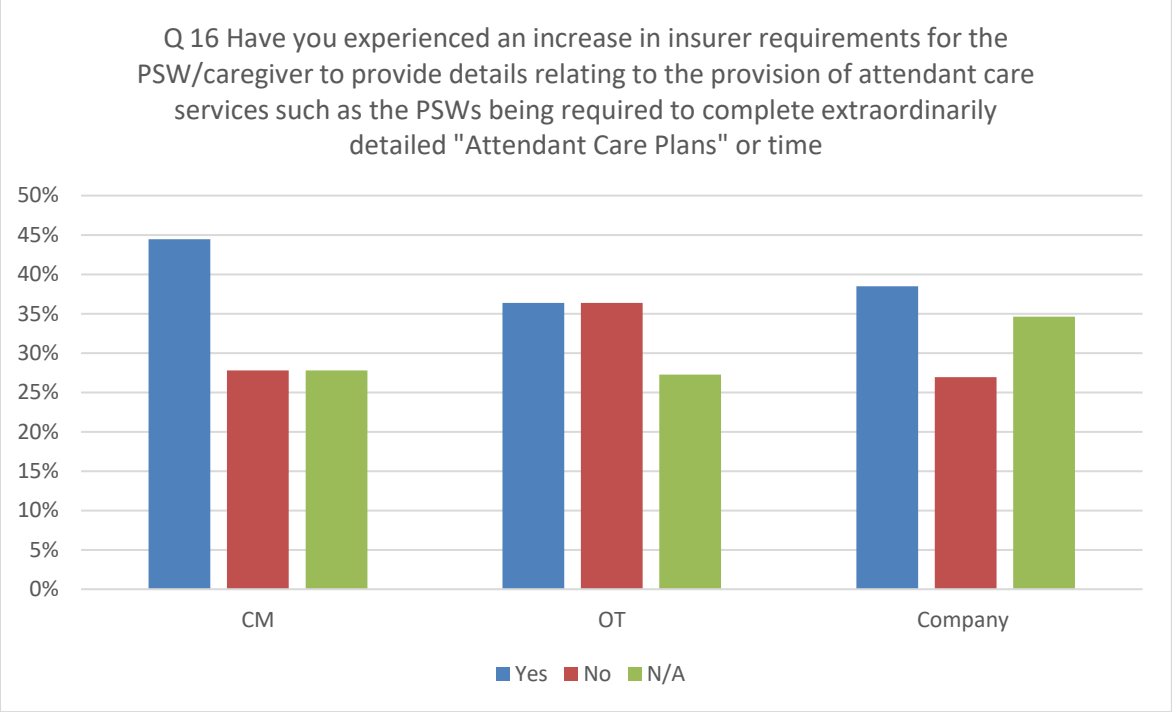

Q14 Clinician Response:
Have you experienced an increase in denials of payment for the following activities with the insurer rationale being that such activities "are a cost of doing business"?
Preparation (7.SF.13)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
CM
OT
SLP
Yes
No
N/A


Q14 Clinician Response:
Have you experienced an increase in denials of payment for the following activities with the insurer rationale being that such activities "are a cost of doing business"?
Brokerage (7.SF.15)
80%
70%
60%
50%
40%
30%
20%
10%
0%
CM
OT
SLP
Yes
No
N/A

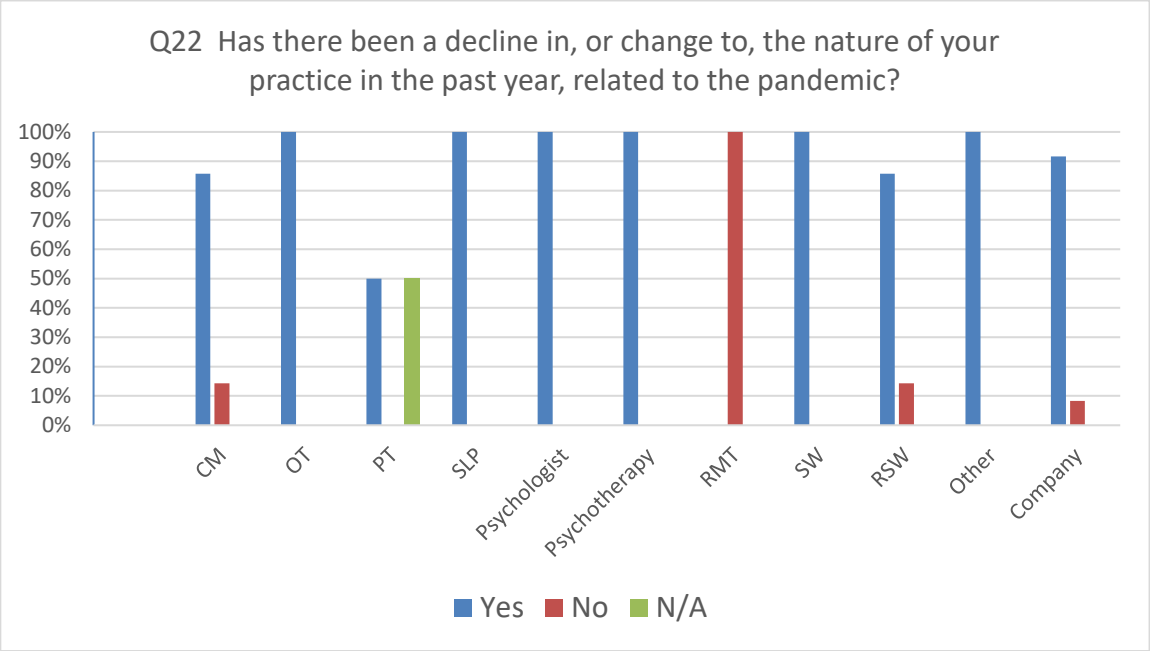
Q 16 Have you experienced an increase in insurer requirements for the PSW/caregiver to provide details relating to the provision of attendant care services such as the PSWs being required to complete extraordinarily detailed "Attendant Care Plans" or timesheets?

40% of respondents from disciplines for which this is relevant reported this taking place.

Some clinicians have observed that Insurers are not informing the claimant that their attendant care benefits have been stopped and, consequently, refuse to pay outstanding invoices.



Q22 Has there been a decline in, or change to, the nature of your practice in the past year, related to the pandemic?



Note: Psychologist, Psychotherapy, RMT & SW categories had a low number of responses and as a result may not be representative.

If yes, please briefly describe the impact on your business:

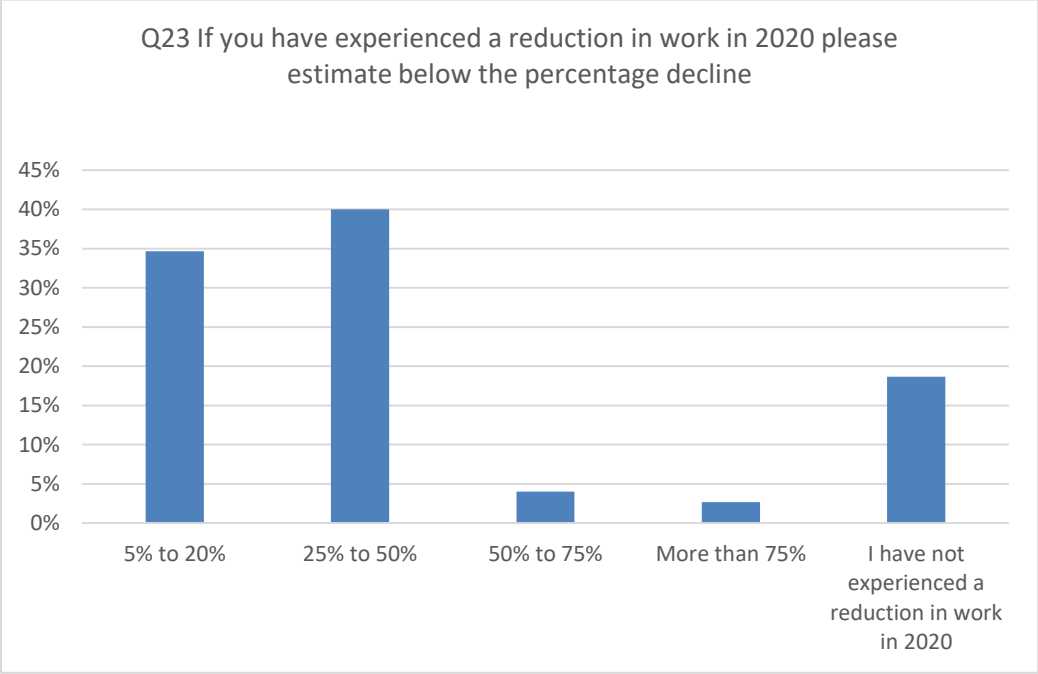
Descriptions of impacts have been organized into the charts, below.

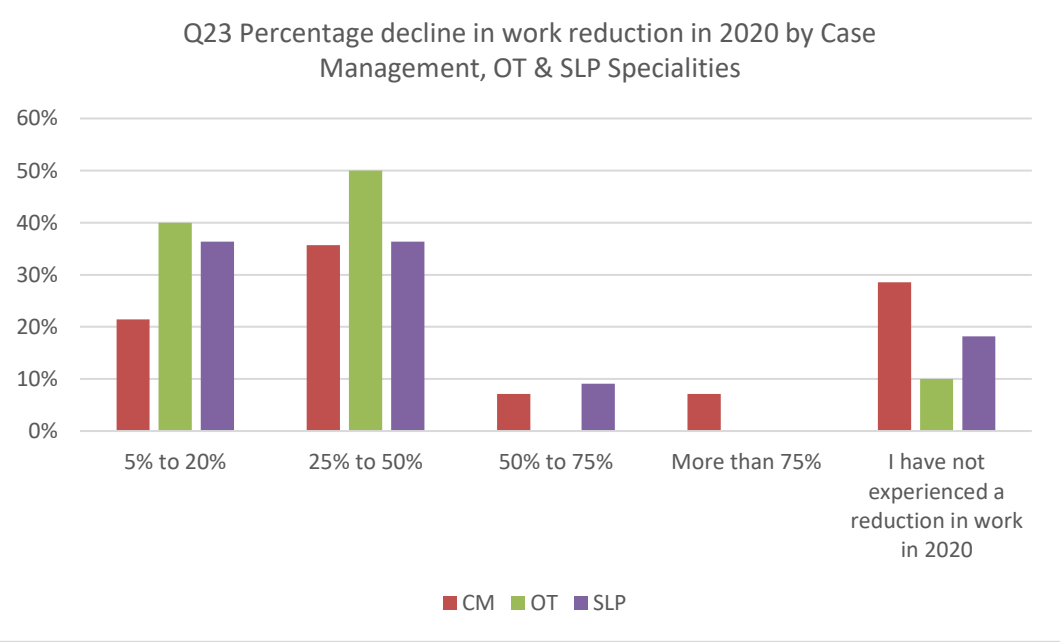
Increased Costs	
Virtual Care	**In person**
Equipment	PPE
Zoom/Telehealth	Equipment
Internet costs	More unpaid time: • client screening • disinfection process • added logistics • more administration required

Decreased Earnings	
Increased insurer denials of indirect time Loss of staff (from the sector or to competitors)	
Virtual Care	**In-Person Care**
Clients opting out of virtual sessions	Disinfection time is unpaid
Shorter session duration	Shorter session duration
Limitations on group session capacity	Additional policy & procedure development
Not all treatment modalities work virtually	Able to treat fewer patients in the same time
More last-minute cancellations	Decreased frequency of visits
	Travel time not covered

Q23 If you have experienced a reduction in work in 2020 please estimate below the percentage decline:

- 81% of all respondents have been financially affected by the pandemic in 2020
- A majority report 25-50% decreased in work.
- OT, SLP & Case Management reporting as the hardest hit.





In addition to the loss of work, clinicians have commented that insurers have been slow to pay invoices; or insurers don't inform clinicians when the Med/Rehab benefits have been exhausted and refuse to pay outstanding invoices for pre-approved services. As well, clinicians report that treatment is often delayed as they are mandated to find payment through the Extended Health Benefit carrier before accessing funding through the auto insurance carrier.

Clinicians also note other factors that have led to a reduction in their caseload and have contributed to greater difficulty in managing the cases they still have including:

- Inflexible insurers, e.g. expecting clinicians to bill exactly how it presents on the OCF-18
- Insurers referring to PPNs without letting the client know they have choice in selecting their treatment provider and that there are other resources available in their community
- Arbitrarily reducing treatment times, and removing equipment and/or delivery costs
- Extended period of time between the IME and the denial
- Insurer/health professional communications are adversarial rather than collaborative and often insurers don't respond back to the clinician
- In an effort to provide assessment or treatment, some clinicians rely on support personnel; for example, the OT who relies on the driving instructor to complete a Driving Assessment. When the insurer refuses to pay the support personnel at their usual and customary rate, the claimant is unable to access a Driving Assessment.