Thomson Rogers – 5 Year Review Conference

A PARADIGM SHIFT[1]

The Auto Insurance 5 Year Review has resulted in a number of FSCO sponsored recommendations which are projected to have a profound impact on the business model currently used by service providers in the industry.

While a final decision regarding any of the proposed changes has NOT yet been made, this analysis will assume the adoption by the government of the recommendations made by FSCO. We have decided to structure this presentation in this manner in order to prepare service providers for the outcomes with the greatest impact on their practices. To the extent that the final decision government mitigates the effect of some provisions the transition will be easier.

This analysis has been structured to provide a summary of the proposed changes, resulting business issues and recommendations outlining strategies to mitigate potential risks.

Reduction in Non CAT cap from $100,000 to $25,000 (FSCO Recommendation #22)

Consideration Points

Is your patient non-catastrophic? Are you sure? Would the patient benefit from an assessment of catastrophic status? Without treatment, will my patient subsequently decompensate and become catastrophic in the future?

Obviously, the easiest way to access greater resources is to have the patient's impairments deemed catastrophic. Strategies and recommendations will be proposed in greater detail by Dr. Harold Becker and Mr. David MacDonald later in the conference.

Some clients have access to group health benefit plans through their place of employment (or from the group health plan of their spouse and/or parent). Quite apart from legal requirements, with the potential reduction in med/rehab coverage, it will be tremendously important to ensure that all forms of collateral coverage have been accessed.

When collateral coverages have been exhausted, and when accident benefit med/rehab limits have been exhausted, some clients will have access to funding sufficient to pay for some of their potential medical/rehabilitation needs. In certain circumstances, it may well be appropriate to ask the patient to pay for ongoing service. Such a result often occurs in non-motor vehicle personal injury matters. In the event that the patient has a viable tort claim, these payments may well be recoverable to the patient, with interest.

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For those patients who have viable tort claims, in certain circumstances, it may be advantageous for the wrongdoer's insurer to consider making a without prejudice advance payment. It is well established that the longer disability persists, the more difficult it is to treat. A number of studies have shown that prolonged absences from the workforce can often result in permanent withdrawal.

With appropriate advocacy, some insurers do make advance payments. Advance payments can be made with terms (i.e. for the specific purpose of accessing rehabilitation).

Potential Business Issues

- For treating clinicians, the reduction in the available cap translates into reduced revenue generated from provision of services to non-cat clients. This in turn is expected to lead to overall decline in demand for rehabilitation/professional services.
- The reduction in revenue may be further exacerbated in the event that FSCO's recommendation #11 is adopted as assessment costs will be deducted from the overall cap thus further reducing funds available for treatment.
- Once the new non-cat cap is reached service providers will have a choice between continuing or stopping treatment.
- To quantify the magnitude of the impact on your practice calculate the average non-cat revenue over the past 12 months. This will represent the total exposure to the proposed decrease in the non-cat cap. The direct impact on your business will depend on the severity of the injuries you treat. The more severe your clients' injuries are the higher will be the impact on your business.
- If service providers choose to proceed with ongoing treatment to such clients, payment for services delivered will be derived from direct regular payment by clients (i.e. out-of-pocket) or proceeds of a future tort settlement. It is widely accepted however, that only a small fraction of the injured population will be able to fund ongoing treatment out-of-pocket for any meaningful period of time. As such, service providers may need to wait until settlement to collect on their invoices.
- Since an average tort settlement may take 3 to 4 years, over time, the combination of no cash inflow (from these specific clients) and regular payments to employees and overhead will affect cash flow.
- To address the imbalance between cash inflows and outflows we offer the following advice:

Management of Cash Inflows	Management of Cash Outflows
• Obtain a Line of Credit • Use services of a factoring or finance company • Invest personal funds to bolster balance sheet and cash position	• Reduce/manage overheads • Provide more in-clinic treatment to minimize out of pocket payment for travel • There might need to be an industry wide paradigm shift in clinician compensation.

- The following are items which service providers should consider when adjusting their practices to the changing landscape:
    - Once the new non-cat cap is depleted FSCO rates no longer apply. In the event that a service provider chooses to carry on with treatment and wait to receive payment at settlement, the fee structure may change. It is recommended to adjust the hourly rate charged to reflect actual market rates for services rather than the artificially low first party rates. To the extent that there is a delay in payment pending resolution of the tort claim, providers may want to consider charging interest.

- Manage your risk by improving case selection. Make sure that cases you select are represented by good lawyers and have a high probability of turning CAT or settling quickly. For instance at-fault victims can not pursue tort so no future settlement can be expected once the initial med/rehab cap is exceeded.
- Prior to OMPP legislation (1990), accident benefit med/rehab limits were capped at $25,000.00, regardless of the severity of injury. In serious cases, where a viable tort claim existed, "undertakings to pay" were commonplace. Attached at Appendix A is a draft "Undertaking To Pay" that you may well wish to incorporate into your practice. There may well be patients who do not wish to sign such a document. Further, in certain scenarios, it may be imprudent for a lawyer to recommend to his/her client that such a document be signed. Undertakings of this kind need to be assessed on a case by case basis.
- Review cash flow on a monthly basis and ideally conduct regular projections especially when adding new staff or taking on additional work.
- Lower demand for services, reduced revenue and cash flow mismanagement will lead to business failures. Industry participants (especially sole providers or smaller practices) may wish to consider consolidation/association with larger players in order to improve financial strength, reduce overheads and increase chances of long term survivors.

Assessments and Treatment Plans will require prior approval by Family Physicians (FSCO Recommendation #15 & 21)

Business Issues

- An appointment of a family physician as "gatekeeper" is expected to reduce the number of overall referrals due to:
  - Some referrals will be declined as they are deemed unnecessary by the family physicians.
  - Physician shortage - approximately 850,000 Ontarians do not have access to a family physician
  - Lack of in-depth understanding of the rehabilitation cycle
  - Lack of in-depth knowledge in certain conditions (eg. TBI)
  - Many family physicians do not usually refer to certain disciplines (eg. social workers)
  - Physicians may refer to their own network of "trusted service providers".

Mitigating factors

- As a decision has not yet been made, it is conceivable that the concept of Family Physicians acting as "gatekeepers" will be augmented by "System Navigators" which may consist of other disciplines such as Nurse Healthcare Practitioners, Social Workers or Occupational Therapists.
- Forge alliances with Family Physicians and/or System Navigators.
- Professional Associations will have to do a better job of promoting their members to Family Physicians and System Navigator professional groups.
- Plan on spending additional time on follow-up with Family Physicians and/or System Navigators to progress or follow up on outstanding OCF 22/OCF18's.
- Larger facilities/clinics may employ the services of Family Physician and/or System Navigators in-house. This may present another good reason for sole practitioners and small practices to seek association with larger facilities.

Convert Housekeeping and Caregiver coverage to an optional benefit (FSCO Recommendation #29)

The conversion of the Caregiver and Housekeeping benefits to optional will translate into reduced demand for assessments to facilitate access to this benefit.

- Certain law firms may decide to pay for such assessments as med-legal reports and part of the tort claim.
- In such events these assessments may need to be conducted simultaneously with other assessments such as Attendant Care Needs.
- The cost of such expanded assessment may be shared between the insurer and the lawyer as it serves a dual purpose.
- You will need an agreement from both the insurer and a lawyer to pay for their proportionate share of the assessment.

Limiting the fee for completion of any forms (Incl. associated assessments and travel) to $200 with all other assessments capped at $2,000 (FSCO Recommendation #12)

and

Limit In-Home Assessments to Attendant Care and Home Modifications (FSCO Recommendation #14)

Business Issues

- Most assessments result in completion of Forms and as such a $200 limit may apply. The fee is inclusive of an assessment, travel and report writing. Many disciplines conduct their assessments in the home setting and produce detailed reports, which easily exceed the $200 cap, and in many cases the $2,000 cap.
- Completion of assessments to the level prescribed by the professional colleges may exceed the newly established caps.
- Sole practitioners and small businesses which do not have physical clinic space (and conduct assessments other than the Attendant Care and Home Modification) will be declined travel and consequently unable to conduct assessments (or commute to the clients home without compensation).

Mitigating Factors

- Minimize overall costs by conducting assessments in the clinic setting.
- If clinic space does not exist providers may consider renting space in professional buildings on an adhoc basis. Such providers may also find it beneficial to join/merge or work in association with other practices which offer clinic space. In such cases clinicians may not be compensated for travel to the clinic for assessment purposes.
- Service providers will have to pay close attention to their clients' addresses to make sure that their clinics are located in reasonably close proximity to their clients to facilitate easy commute.
- Reports produced to access AB will have to evolve to contain information that is relevant and concise. Professional associations may have to work with their members to derive at such new recommended templates.

- To the extent that a tort case exists legal representatives may ask for a detailed report (to be used for tort purposes). In such cases legal representatives will pay for such a report/assessment (or a portion of it if conducted alongside an AB assessment).
- We believe that victims in remote locations will be further disadvantaged.

Revoking of the Section 42.1 "Rebuttal Assessments" (FSCO Recommendation #20)

The cancellation of funding for the purposes of the Rebuttals will result in a lack of opportunity to convey disagreement with, or concerns related to a Section 42 Assessment.

In certain instances the legal representative may request and pay for completion of a Rebuttal report. Pricing of such tasks will be determined by the service providers on an individual basis.

Conclusion

If the non-catastrophic med/rehab limits are reduced to $25,000.00, and other FSCO recommendations discussed in this paper materialize, there will be hardship for which there is no perfect solution. Efforts must be made to maximize rehabilitation dollars. Advocacy and creativity may help innocent accident victims access necessary med/rehab funding.

APPENDIX A

UNDERTAKING TO PAY

TO: How Can I Help
Barristers and Solicitors

FROM: Ms. Injured

I, Ms. Injured, suffered impairment as a consequence of a motor vehicle accident that occurred on (X date).

As a consequence of the accident, it has been recommended to me that I receive further rehabilitation.

Save My Life Rehab Company has agreed to render services to me and to defer payment of its account.

I, Ms. Injured, irrevocably authorize and instruct How Can I Help, Barristers and Solicitors, to pay to Save My Life Rehab Company its full account, plus interest at the rate of X per cent per year, from the proceeds of any settlement and/or Judgment monies that I receive as a consequence of my motor vehicle accident claims.

This undertaking to pay is effective up the principal amount of X dollars, plus interest, after which, a new undertaking to pay is required.

Dated this day of , at , in the Province of Ontario.

_____ _____

Witness Ms. Injured

_____ _____

Witness Save My Life Rehab Company

APPENDIX B
REPORTING

In those situations, where accident benefit med/rehab funding is expected to be insufficient, efforts should be made to maximize the funding available for treatment. A potential way to do so is to reduce the time spent preparing extensive reports.

In the accident benefit context, consideration should be given to the following:

- Where possible, standardized reports that can be easily amended to fit the unique circumstances of your patient;
- Bullet point reporting;
- Attaching handwritten clinical notes as opposed to summarizing each and every interaction with a patient;
- Attaching medicals as opposed to summarizing their contents.

If the scope of your reporting goes beyond what is required in the accident benefit context, and if there is a viable tort claim, some lawyers will entertain the concept of sharing the cost of report preparation. For instance, consider the following example:

- The patient has a viable tort claim;
- The patient is not able to access housekeeping/home maintenance benefits from the accident benefit insurer;
- Compensation for housekeeping/home maintenance is available in the tort claim;
- An occupational therapist is to attend upon the patient to determine attendant care requirements.

In the above-noted construct, for the purposes of accident benefits, there is no mandate for the therapist to comment upon housekeeping/home maintenance needs. Nevertheless, it may be an important piece of information for the purposes of a tort claim. In this context, it might well be appropriate for the cost of the report to be divided (i.e. a portion of the cost paid by the accident benefit insurer and the remainder paid by the lawyer).

With many law firms, the practice of paying for reports (as distinct from treatment) is commonplace and considered to be “the cost of doing business”.