

## **WHAT'S HAPPENING AT FSCO? THE LEGATE SABS UPDATE**

For the week of June 8 to 12, 2009

### **FSCO Five Year Review: Recommended Amendments to S.24 Assessments**

The March 31, 2009 Report on the Five Year Review of SABS released by the Superintendent of FSCO raises some concerns with the complexity of SABS and an overutilization of assessments in the SABS system. The data shows that for each dollar spent on treatment, another 60 to 80 cents is spent on assessments. Other concerns are that insurers are being overwhelmed by multiple requests for assessments and that SABS assessments are increasingly taking the form of medico-legal examinations for the tort system. FSCO says that s. 24 assessments were created to address clinical assessments required as part of the treatment process and consideration was never given to establishing limits for these expenses. In order to reduce the over-reliance on these s.24 assessments for simply justifying entitlement rather than to guiding clinicians, FSCO has recommended certain SABS amendments, including the following:

- (#11) Assessment expenses should be subject to the same maximum monetary and time limits that apply to med/rehab benefits.
- (#12) The fee for completing forms should be capped at \$200 and the cost of all other assessments should be capped at \$2,000.
- (#13) Insurers should have 10 business days instead of 3 to respond to an application for an assessment.
- (#14) "In-home Assessments" should be limited to the seriously injured and only used for evaluating AC needs and home modifications.
- (#15) Assessment requests should be completed only after a referral is made by the primary health professional (family doctor in most cases).
- (#17 and #24) CAT Assessments and Form 1 assessments should be conducted only by practitioners with appropriate training and experience.
- (#33) The cost of future care cost reports should not be an expense recoverable under the SABS.

#### **Implications:**

This report raises a concern with the complexity and cost of the current SABS regime, but it also addresses the need to enhance auto insurance consumer protection. The recommendations that extend the time for insurers to respond to assessment requests, and that enhance assessor qualifications, may be seen as reducing complexity and costs without significantly impacting consumer protection. The more time to consider assessments that are presumably more accurate, the less need there may be for insurer examinations in some cases.

However, it appears that the remainder of the s.24 recommendations may diminish consumer protection and only increase complexity or costs:

- It would seem to detract from consumer protection if the costs of s.24 assessments were to be paid out of the med/rehab limits that are also recommended to be reduced to \$25,000 for non-catastrophic claimants.
- There are other concerns raised in this FSCO report regarding the loss of experienced assessors as a result of health care provider fee restrictions. Accordingly, perhaps the capping of the costs for completing forms and assessments will have the undesired effect of leaving the system with a greater proportion of less experienced providers and more insurer challenges.
- With regard to the “In-home Assessment” restrictions, this appears to attempt to address travel costs of assessors to claimants’ homes. It seems unrealistic to transfer these assessments into a clinical setting when occupational therapy in terms of improving function in the home is conducted and monitored by the OT in the home. The result of eliminating in-home assessments but for attendant care and home modification assessments also seems to be inconsistent with the SABS provision for medical treatment by an OT. Further, how is the insurer or the treating OT to know what level of OT treatment is reasonable and necessary for each claimant unless there is an assessment of the claimant within their unique home environment? This recommendation would seem to lead to a greater level of uncertainty and, thus, a further reliance on s.42 assessments to evaluate OT treatment plans.
- The recommended requirement of a referral from a family doctor before a request for an assessment appears to add further unnecessary complexity into the benefit request process. In many cases, the family doctor is not involved beyond the initial consultation following the injury and only briefly on any other occasion. The therapists treating the claimant on a regular basis see the needs of the claimant in a more activity-related or practical environment and, it is submitted, they are likely in a more informed place to observe deficits and evaluate ongoing assessment/treatment needs.
- FSCO suggests that FCC assessments are not requested by health care providers in terms of accessing benefits but rather are requested by lawyers in settling claims. However, I would suggest that the FCC report is important to SABS claimants in planning rehabilitation and managing limited SABS resources. There is not always a tort claim and, where there is, there may still be limited future resources. The planning of a claimant’s rehabilitation or care must balance present and future needs when there are limited resources. FCC assessments necessarily inform claimants about the choices that must be made regarding ongoing med/rehab and attendant care needs.

### Accessing Arbitration Decisions

The FSCO Report on the Five Year Review of Automobile Insurance can be found at: [www.fSCO.gov.on.ca/English/insurance/auto/5yr-review/FiveYearReviewReport.pdf](http://www.fSCO.gov.on.ca/English/insurance/auto/5yr-review/FiveYearReviewReport.pdf)

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