Alberta Treasury Board and Finance

INTERPRETATION BULLETIN

BULLETIN NUMBER: **09-2014**

TITLE: **RENEWED DIAGNOSTIC AND TREATMENT PROTOCOLS REGULATION (116/2014) – AUTO INSURANCE UPDATE – IMPORTANT CHANGES AND REMINDERS**

DATE: **September 2014**

NOTE: The original Diagnostic and Treatment Protocols Regulation (122/2004) (DTPR) applies to any collisions occurring **on or before June 30, 2014**. Bulletin 08-2005 still applies to these collisions.

PURPOSE

This Bulletin updates Bulletin 08-2005 for the purposes of the renewed Diagnostic and Treatment Protocols Regulation (116/2014) (DTPR), which came into force on July 1, 2014.

This Bulletin applies to collisions occurring on or after July 1, 2014. For collisions occurring on or before June 30, 2014, please refer to Bulletin 08-2005.

CLAIM FORMS

Form	Changes and reminders
AB-1 Notice of Loss and Proof of Claim	**Important reminders:** • This form must be completed and submitted by patients within 10 business days of their motor vehicle collision. Primary health care practitioners should inform their patients of this requirement. • Practitioners should **not** complete or submit the Notice of Loss and Proof of Claim form (AB-1). There is no fee for completing this form.
AB-2 Treatment Plan	**Important reminders:** • This form is to be completed by the primary health care practitioner who will be actively engaged in the assessment and continuing care of the patient. *Continued on next page…*

AB-2 Treatment Plan (continued)	• If a primary health care practitioner refers a patient for treatment, it is important for the referring practitioner to advise whether or not they have completed the AB-2 form. He or she should provide a copy to the other practitioner(s) for their reference if one has been completed. • The primary health care practitioner (the physician, chiropractor or physical therapist who completes the AB-2 form and is actively engaged in the continuing care of the patient) must be explicit as to the treatment method(s), as only the treatment prescribed on the AB-2 form is preauthorized for payment. • If the insurer has already paid a primary health care practitioner for completion of the AB-2 form, the insurer is not obliged to pay for a second AB-2 form. • Practitioners are reminded that the AB-2 form should be completed and submitted to the insurer within 10 business days of the first assessment of the patient. • Copies of the AB-2 form should be provided to insurer, the practitioner(s) providing treatment, and the patient.

NUMBER OF TREATMENT VISITS

Reminder	Under the Diagnostic and Treatment Protocols Regulation, all patients may receive up to a maximum of 10 or 21 preauthorized payments for treatment visits, depending on the type of injury. However, it is important to remember that, should this number of treatment visits be insufficient to address the injury, patients can still claim treatment visits covered under other plans. For many patients coverage is available under extended health benefits (e.g., Blue Cross or similar employee benefit plans) or from the patient's automobile insurer under Section B of the Standard Automobile Insurance Policy (SPF#1). The SPF#1 is available at: https://www.alberta.ca/automobile-insurance.aspx

WHIPLASH ASSOCIATED DISORDER (WAD)

Clarification	For the purposes of the Diagnostic and Treatment Protocols Regulation, injuries related to the spine should be diagnosed and treated in accordance with the criteria set out under *Division 2 – Diagnostic and Treatment Protocol for Whiplash Associated Disorder*

WAD Clarification (continued)

Injuries – Cervical, Thoracic, Lumbar and Lumbosacral (sections 10-14 of the Diagnostic and Treatment Protocols Regulation).

When diagnosing injuries related to the spine as either a WAD I or WAD II, practitioners shall include the International Classification of Diseases (ICD-10-CA) codes when filling out the Treatment Plan AB-2 form. See the chart below for guidance.

INJURY	DTPR DIAGNOSIS	ICD-10-CA
Cervical (WAD I or II)	Whiplash Associated Disorder **(WAD I)** with complaint of neck pain, stiffness or tenderness (no physical signs, whiplash not otherwise specified)	S13.40
	Whiplash Associated Disorder **(WAD II)** with complaint of neck pain with musculoskeletal signs (decreased range of motion and point tenderness)	S13.41
Thoracic (WAD I or II)	Sprain and strain of thoracic spine **(WAD I or II)**	S23.3
Lumbar / Lumbosacral (WAD I or II)	Sprain and strain of lumbar spine **(WAD I or II)**	S33.5

Treatments for WAD III and WAD IV injuries are not authorized under the Diagnostic and Treatment Protocols Regulation. However, an assessment to determine the severity of a WAD injury is permitted, and the fee shall be covered by the insurer and shall be paid in accordance with the applicable Notice of Fees and Disbursements (see Bulletins and Notices).

TREATMENT VISITS AND RELATED FEES: 3 of 10, or 7 of 21 Treatment Visits

Notice

With respect to practitioner fees for patient treatment visits, fees will be applied according to how many treatment visits with all practitioners a patient has already attended. This clarifies which regulated fee amount Physical Therapists may charge when treating a patient (as described in Information Bulletin 04-2013).

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Treatment Visits and Related Fees (continued)

A Physical Therapist may charge $83 for a treatment visit if the visit is a patient's 1st, 2nd or 3rd (including all other permitted practitioner visits attended) of the maximum of 10 preauthorized injury treatments, or if the visit is a patient's 1st, 2nd, 3rd, 4th, 5th, 6th, or 7th (including all other practitioner visits attended) of the maximum of 21 preauthorized injury treatments.

If the patient has already attended 3 (of a maximum of 10 preauthorized) or 7 (of a maximum of 21 preauthorized) treatment visits with any of the permitted practitioners, a Physical Therapist may only charge $41 for any further treatment visits with the patient.

The fee for the treatment visit is not applied according to how many treatment visits the Physical Therapist has provided to a patient. It is applied according to how many treatment visits with all permitted practitioners that a patient has already attended.

Example

As illustrated in the following example, the patient's number of treatment visits attended determines how a primary health care practitioner's treatment visit fee will apply (as described in Bulletins 01-2005, 04-2013 and 05-2013).

Adjunct therapy (including massage therapist or acupuncturist) visits prescribed on the Treatment Plan AB-2 form will always count towards a patient's number of preauthorized payments for treatment visits.

For example, if a patient has been diagnosed with a WAD I injury, he or she may utilize up to a maximum of 10 preauthorized payments for treatment visits.

Treatment Visit 1	Treatment Visit 2	Treatment Visit 3	Treatment Visit 4	Treatment Visit 5
Physical Therapist $83	Physical Therapist $83	Massage Therapist $ MT rate	Physical Therapist $41	Chiropractor $38

PRIMARY HEALTH CARE PRACTITIONER SCOPE OF PRACTICE

Notice	Treatments that are within a primary health care practitioner's scope of practice are subject to that primary health care practitioner's regulated fee schedule (as described in Bulletins 01-2005, 04-2013 and 05-2013). This includes any treatment authorized by the Diagnostic and Treatment Protocols Regulation that the primary health care practitioner provides himself or herself. The fee for the treatment visit is determined by the fee schedule for that type of practitioner, and is dependent on the patient's preauthorized treatment visit number (as discussed above).

EXTRA BILLINGS AND SUPPLIES

Reminder	*Extra Billings* The treatment visits under the Diagnostic and Treatment Protocols Regulation are intended to be free of any financial and administrative barriers that might limit patients seeking early, appropriate treatment for their injuries. "Extra" (or balance) billing practices pose a financial barrier as well as stress to a patient; therefore, **practitioners may not extra-bill**. This prohibition is set out in section 5 of the Diagnostic and Treatment Protocols Regulation and Bulletins 01-2005, 04-2013 and 05-2013. *Supplies* The Diagnostic and Treatment Protocols Regulation are intended to provide patients with access to supplies required for self-care, and are intended to prohibit any financial barriers a patient may have to access these potentially necessary items. Items are eligible to be claimed provided that they are itemized on the invoice, they assist the patient with necessary self-care, and they are reasonably priced. These are supplies that a patient would utilize, usually in the home, such as exercise balls, tensor bandages, and cold packs. This provision is not intended to cover a practitioner's overhead expenses or in-clinic consumption items.

This Bulletin is provided under the authority of the *Insurance Act* and relevant regulations. It provides the latest information on changes to the process and requirements for diagnosing, treating, and making claims under the automobile insurance regulations. This information is subject to change. If there is any inconsistency between this Interpretation Bulletin and the *Insurance Act*, the Diagnostic and Treatment Protocols Regulation, and the Automobile Accident Insurance Benefits Regulation, the latter Act and Regulations prevails.

Bulletins and additional information about automobile insurance changes are available online at http://www.finance.alberta.ca/business/insurance/index.html .

Patients with questions or concerns may be directed to their claims adjuster.

Any other questions regarding the contents of this Notice may be directed to the Office of the Superintendent of Insurance, either by e-mail at TBF.insurance@gov.ab.ca, or by telephone at (780) 427-8322 (toll-free in Alberta by first dialing 310-0000).

[ORIGINAL SIGNED]

Mark Prefontaine
Superintendent of Insurance