Alberta Treasury Board and Finance

INTERPRETATION BULLETIN

BULLETIN NUMBER:	**08-2014**
TITLE:	**RENEWED DIAGNOSTIC AND TREATMENT PROTOCOLS REGULATION (116/2014) – AUTO INSURANCE UPDATE**
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 02-2005 still applies to these collisions.

PURPOSE

This Bulletin updates Bulletin 02-2005 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 02-2005.

1. DIAGNOSTIC AND TREATMENT PROTOCOL REGULATION FORMS

Form	Notes
AB-1 Notice of Loss and Proof of Claim	• The form should be completed by the patient or, if required, by his or her designate, within 10 business days of their collision. • The patient or his or her designate can obtain the form from the insurer or the government website. • Practitioners should **not** complete or submit the AB-1 form. There is no fee for completing this form.
AB-1a Claim for Disability Benefits	• This form is to be completed **only** by physicians, at the request of the insurer. • Physicians can claim the fee for completing this form directly from the patient or his or her insurer. • The patient or his or her designate can obtain the form from the insurer or the government website.
AB-2 Treatment Plan	• 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. • The form shall be completed within 10 days of the first visit or soon as practicable.

AB-2 Treatment Plan (continued)	• The form shall be sent directly to the insurer for payment. • The patient, or his or her designate, can obtain the form from his or her insurer, or the government website. • The insurer is not obliged to pay for the form until it has been fully and correctly completed.
AB-3 Progress Report	• This form shall be completed **only** at the request of the insurer and **not** at the request of the patient. • The form will be sent by the insurer to the primary health care practitioner. It is available on the government website. • The primary health care practitioner shall bill the insurer directly.
AB-4 Concluding Report	• This form should be completed by the primary health care practitioner who provided the majority of treatment visits. • It shall be completed at the conclusion of treatment visits. • **This form is mandatory for all cases being treated under the Diagnostic and Treatment Protocols Regulation, when a Treatment Plan AB-2 form has been completed.** • The form can be obtained by the patient, or his or her designate, from his or her insurer, or the government website. • The primary health care practitioner shall send this form to the insurer with the last invoice for treatments authorized by the Diagnostic and Treatment Protocols Regulation. • A copy of the invoice shall be sent to the patient with an information letter (see Section #6 - General Comments for further instruction). • The insurer is not obliged to pay for the form until it has been fully and correctly completed.
AB-5 Referral Form to an Injury Management Consultant	• This form shall be completed by the primary health care practitioner who is requesting a consultation. • The primary health care practitioner **does not** require authorization from the insurer to refer a patient to an Injury Management Consultant. However, as a best practice, a primary health care practitioner considering a patient referral to the Injury Management Consultant should notify the insurer of his or her intent whenever possible. • The form is available from the insurer or the government website. • The primary health care practitioner shall bill the insurer directly. • The insurer is not obliged to pay for the form until it has been fully and correctly completed.

Alert

The insurer is only required to pay for one completed assessment and Treatment Plan AB-2 form. Physician assessments are covered by Alberta Health Care Insurance.

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A patient may have gone to more than one primary health care practitioner for assessment and treatment of their injury. **The primary health care practitioner shall ask the patient if he or she has contacted other primary health care practitioners about the injury, document the actions taken, and contact the insurer prior to attending the patient.**

Where a primary health care practitioner has taken and documented that action (e.g., contacting the insurer), and the insurer advises that no other Treatment Plan AB-2 form has been submitted or is anticipated, then invoices for the assessment, completing the AB-2 form, and providing treatment will be honored by the insurer. If the insurer has been notified and failed to respond to the primary health care practitioner, payment for the services provided will be paid. The patient shall confirm the name of their primary health care practitioner with his or her insurer.

Where a patient chooses to engage another primary health care practitioner after the initial assessment and completion of the Treatment Plan AB-2 form, the "new" primary health care practitioner may bill the patient directly for their assessment and completion of the AB-2 form. This amount is not recoverable from the insurer under Section B – Accident Benefits of the Automobile Accident Insurance Benefits Regulation.

2. DIAGNOSTIC AND TREATMENT PROTOCOL REGULATION FORMS

Clarifying the purpose

The purpose of a referral to an Injury Management Consultant (IMC) is twofold:

- To establish or confirm a diagnosis; and/or
- To provide recommendations on the best treatment options to facilitate recovery.

The purpose of a referral to an Injury Management Consultant is not to gain approval for additional treatment visits beyond the 10 or 21 treatments based on the type of injury. If additional treatment visits are required beyond the 10 or 21 treatments (based on the type of injury), the Diagnostic and Treatment Protocols will no longer apply. Other benefits may be available through the patient's extended health care benefits, or under Section B – Accident Benefits of the Automobile Accident Insurance Benefits Regulation.

Timing

Referrals to an Injury Management Consultant are made by the primary health care practitioners, not the insurer, prior to 10 or 21 treatments (based on the type of injury) being concluded, and within 90 days of the collision. The primary health care practitioner does not require authorization from the insurer to refer a patient to an Injury Management Consultant.

At any time after 10 or 21 treatment visits (based on the type of injury) are exhausted, or 90 days has lapsed since the date of the accident, insurer authorization is required for an IMC referral.

Advising Insurers

Authorization from the insurer is not required for a primary health care practitioner to refer a patient to an Injury Management Consultant. However, as a best practice, the primary health care

practitioner considering a patient referral to an Injury Management Consultant should advise the insurer of his or her intent whenever possible. If a referral by the primary health care practitioner is requested, a copy of the completed Referral Form AB-5 shall be provided to the insurer.

Injury Management Consultant Reports

Injury Management Consultant reports shall be completed and returned to the primary health care practitioner within 10 days of the assessment by the Injury Management Consultant. A copy shall be provided to the insurer. The report shall contain the following information:

- Patient name and claim number
- Name of referring primary health care practitioner and reason for the referral
- Summary of the history and examination of the patient
- Diagnosis and specific recommendations for managing the injury

Fees

The fee for an Injury Management Consultant's assessment, which includes the cost of the report, shall be sent directly to the insurer.

Conflict of Interest

Referral to an Injury Management Consultant must be in the best interest of the patient. Generally, an Injury Management Consultant referral shall not be to a health practitioner working within their own clinic, clinical group, or where the primary health care practitioner has a financial interest. Disclosure to the patient and insurer of a perceived conflict of interest is considered good practice. It is always prudent to consult with your regulatory body on any professional matter.

3. DIFFERENCES IN DIAGNOSIS

When primary health care practitioners have different opinions on the diagnosis of a patient, the primary health care practitioner who completed the Treatment Plan AB-2 form will establish the working diagnosis.

Primary health care practitioners are expected to discuss and resolve their differences. However, if this is not possible, referral to an Injury Management Consultant will be considered.

An insurer does not have the right to choose a preferred diagnosis.

4. WHIPLASH ASSOCIATED DISORDER (WAD)

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 Injuries – Cervical, Thoracic, Lumbar and Lumbosacral* of the Diagnostic and Treatment Protocols Regulation.

Primary health care practitioners must also satisfy the standards referenced below when diagnosing WAD injuries.

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WAD I criteria:

- symptoms of spinal pain, stiffness or tenderness
- no demonstrable, definable and clinically relevant physical signs of injury
- no tenderness and normal range of motion
- normal reflexes and muscle strength in the limbs
- no objective, demonstrable, definable and clinically relevant neurological signs of injury
- no fractures to or dislocation of the spine

WAD II criteria:

- symptoms of spinal pain, stiffness or tenderness
- musculoskeletal signs of decreased range of motion of the spine, and point tenderness of spinal structures affected by the injury
- paraspinal tenderness and restricted spine range of motion
- normal reflexes and muscle strength in the limbs
- no objective, demonstrable, definable and clinically relevant neurological signs of injury
- no fracture to or dislocation of the spine

WAD III criteria:

- objective, demonstrable, definable and clinically relevant neurological signs of injury
- abnormal reflexes and/or muscle weakness, often with sensory changes in a dermatomal pattern suggesting nerve root impingement
- no fracture to or dislocation of the spine

WAD IV criteria:

- fracture to or dislocation of the spine
- neck pain, possibly neurological symptoms in limbs, urinary incontinence due to spinal cord involvement
- possible hyperreflexia, positive Babinski's sign, motor weakness and sensory changes suggesting spinal cord injury

Though the treatment of WAD III or WAD IV injuries are not authorized under the Diagnostic and Treatment Protocols Regulation, until an assessment under (and covered by) the Diagnostic and Treatment Protocols Regulation is completed, the patient and injury remain within its scope. The assessment fee shall be covered by the insurer and the fee payable shall be in accordance with the applicable Notice of Fees and Disbursements. See Bulletins and Notices: https://open.alberta.ca/dataset/superintendent-of-insurance-bulletins-and-notices

5. NUMBER OF TREATMENT VISITS

Under the Diagnostic and Treatment Protocols Regulation, all patients may receive up to 10 or 21 treatment visits based on the type of injury.

A primary health care practitioner indicating on the Treatment Plan AB-2 form that the patient can be treated with fewer visits does not prevent the patient from receiving the full 10 or 21 treatments (based on the type of injury) **when required**.

Physician visits are covered by Alberta Health Care Insurance and are not included in:

- the 10 or 21 treatments based on the type of injury, or
- the number of assessments available to the patient.

6. GENERAL COMMENTS

- Payment by insurers for services provided under the Diagnostic and Treatment Protocols Regulation must be within 30 days of receipt of the invoice.
- Payment for a report may not be honored if documents are incomplete or illegible.
- Practitioners are responsible to have an internal administrative process to verify the services provided to patients.
- When generating the final invoice to the insurer, a copy of the invoice shall be mailed to the patient with a standard letter that indicates the following: "Your insurer has been billed in the amounts shown for all goods and services listed. Please review the invoice and report any errors to the signatory or your insurer."
- The Diagnostic and Treatment Protocols Regulation is intended to cover services provided by primary health care practitioners (defined as physicians, physical therapists and chiropractors) and adjunct therapy practitioners (massage therapists and acupuncturists). The provision of other services listed under Section B – Accident Benefits of the Automobile Accident Insurance Benefits Regulation (such as dental services, psychological services, occupational therapy, etc.) to the patient is permitted to occur simultaneously. The provision of these services does not cancel preauthorization of services under the Diagnostic and Treatment Protocols Regulation by primary health care practitioners and adjunct therapy practitioner.
- Adjunct therapies will only be preauthorized when directed by the primary health care practitioners, which is documented on the Treatment Plan AB-2 form. If adjunct therapies have not been preauthorized under the Diagnostic and Treatment Protocols Regulation, patients can still seek to obtain those services under Section B – Accident Benefits of the Automobile Accident Insurance Benefits Regulation.
- If a patient misses an appointment or is late for an appointment, the insurer is not responsible under the Diagnostic and Treatment Protocols Regulation for reimbursing the primary health care practitioner or adjunct therapy practitioner for that time. The primary health care practitioner or adjunct therapy practitioner may charge the patient a late or missed appointment fee in accordance with any directive from the respective licensing organization.
- For help locating or contacting a claims adjuster, please contact the Insurance Bureau of Canada by telephone at 1-800-377-6378.
- Further information related to the establishment of fees, form amendments and related issues shall be forwarded to your respective professional associations and published in an Interpretation Bulletin at: https://open.alberta.ca/dataset/superintendent-of-insurance-bulletins-and-notices

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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:

- Bulletins: https://open.alberta.ca/dataset/superintendent-of-insurance-bulletins-and-notices
- Automobile insurance: https://www.alberta.ca/automobile-insurance.aspx

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).

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