

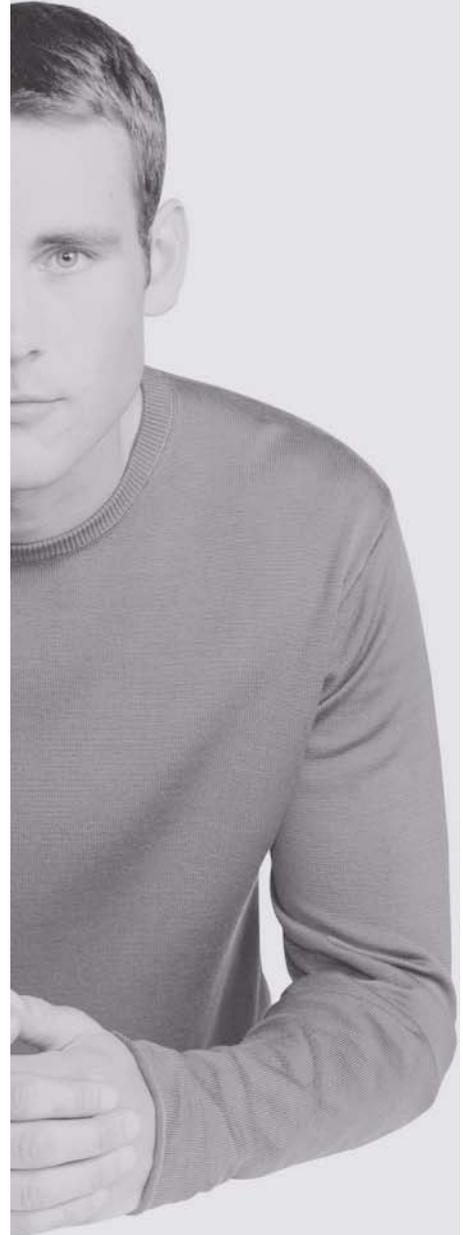
What do  
provincial changes  
in motor vehicle  
insurance  
mean for Alberta's  
primary health care  
practitioners?

*A guide for diagnosis,  
treatment and claims*

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Interpretive Bulletin  
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**Alberta**



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# General Information



October 1, 2004

## Introduction

Important changes have been made to Alberta's Insurance Act Regulations. As part of these changes, new protocols have been established for the diagnosis and treatment of minor injuries associated with motor vehicle collisions. The changes and the new treatment protocols come into effect October 1, 2004.

The over-riding objective is to ensure that people who are injured in collisions receive fast and effective treatment to support their recovery. The changes are the result of an extensive review of the current processes and requirements related to treatment and claims for minor injuries. Prior to the changes in the Insurance Act Regulations, individuals who were injured in a motor vehicle collision required approval from their insurer's medical advisor before treatment and/or rehabilitation could begin. This could cause delays and disagreements over the type and extent of treatment required. Early diagnosis and treatment is known to speed up recovery and help individuals return to work and their normal activities of daily life.

The new process is designed to:

- Ensure that individuals with minor injuries do not have to wait for approval from their insurance company before treatment begins
- Use the best available evidence to guide diagnosis and treatment
- Provide an effective process for treating people with minor injuries while, at the same time, providing an avenue for review for individuals who are not recovering as expected.

This guide provides a summary of important changes that affect primary health care practitioners – specifically physicians, chiropractors, and physical therapists. It includes information about the diagnosis and treatment protocols and how they should be applied. It is intended to be a guide to the regulations. The guide also contains information about how to process claims and billings for the treatment of minor injuries.

## Scope of the Diagnosis and Treatment Protocols

Diagnosis and treatment protocols have been developed in consultation with primary health care practitioners. The protocols are based on the best available research and evidence. The protocols apply specifically to three types of injuries: sprains, strains and whiplash-associated disorders (WAD). Other injuries such as fractures, internal injury, etc. are excluded from these protocols.

This guide summarizes the protocols for the diagnosis and treatment of strains, sprains and WAD injuries.

The use of the protocols is intended to streamline the process for both patients/claimants and primary health care practitioners. If the protocols are followed, primary health care practitioners do not have to seek approval of the insurer for payment for treatment of these injuries but should notify the insurer of the claim. Primary health care practitioners will then be able to bill the auto

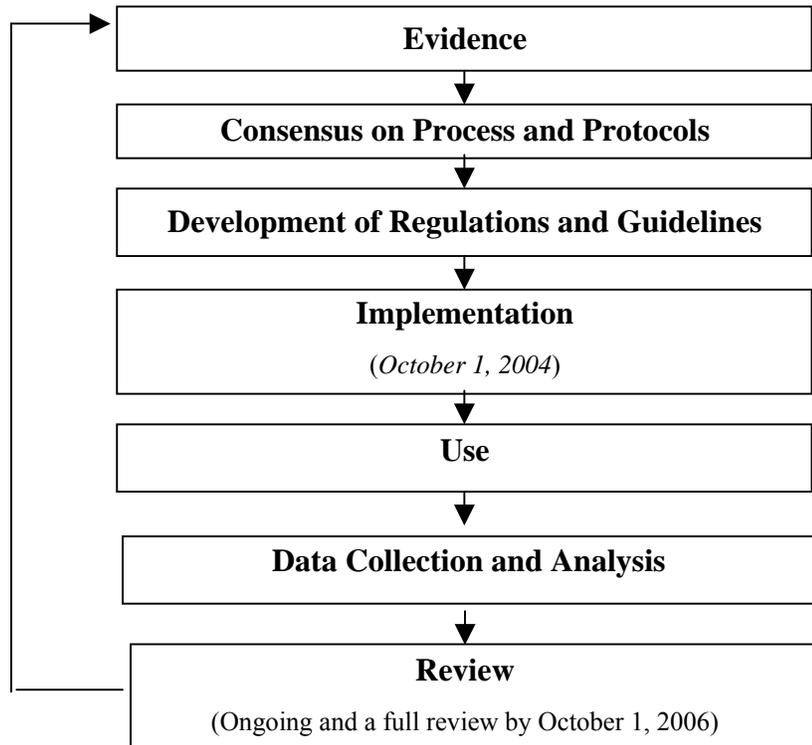
insurer directly for all treatment services outlined in the protocols, unless covered by Alberta Health Care Insurance.

The protocols specifically outline the types of treatments recommended for strains and sprains and WAD injuries. The protocols place specific limits on the number of visits and treatments required. At the same time, if the primary health care practitioner is uncertain about the nature of the injury, or believes that the injury is not resolving appropriately or in the expected timelines, the primary health care practitioner can refer the patient/claimant to an injury management consultant. The injury management consultant can provide advice and a report on the diagnosis and treatment of the patient/claimant and also recommend a further assessment or multi-disciplinary assessment of the injury.

It is important to note that the Insurance Act Regulations set out a general approach to the treatment of minor injuries associated with motor vehicle collisions. The Regulations do not prevent or limit a patient/claimant or a primary health care practitioner from asking an insurer to authorize investigations or treatments beyond the specified limits.

In the ever-changing arena of health care, it is naive to expect that the protocols and supporting processes would be absolute and final. Ongoing research and study will likely identify better means of managing these types of injuries. It is also likely that some aspects of the processes may need to change to address concerns from insurers, primary health care practitioners, patients/claimants and other stakeholders. The introduction of the protocols should be viewed as one of many steps in the ongoing process of treating injured patients/claimants. The following diagram outlines the steps required to ensure that the protocols and supporting process are effective, efficient, appropriate and timely.

## Process for Developing and Reviewing Processes and Protocols



## Definitions

For the purposes of this guide:

- ***Evidence-based medicine*** - means the conscientious, explicit and judicious use of current best practice in making decisions about the care of a patient/claimant, integrating individual clinical expertise with the best available external clinical evidence from systematic research
- ***Injury management consultant*** - means a primary health care practitioner (medical doctor, chiropractor, or physical therapist) who is entered on the IMC (Injury Management Consultant) register
- ***Strain*** - means an injury to one or more muscles
- ***Sprain*** - means an injury to one or more of the tendons or ligaments, or to both
- ***WAD injury*** - means a whiplash associated disorder *other than* one that exhibits one or both of the following:
  - objective, demonstrable, definable and clinically relevant neurological signs
  - a fracture to or a dislocation of the spine.

## Evaluation and follow-up

The diagnostic and treatment protocols are based on the latest research evidence and have been developed in consultation with health care practitioners. Information and data on the implementation of these protocols will be collected on an ongoing basis. This information is critical to evaluate the effectiveness of the protocols and to make changes as necessary.

Non-identifying information regarding sample claims will be provided to the Superintendent of Insurance, or his agent/designate, to monitor the effectiveness of the system and the regulations. The Senior Medical Advisor to the Superintendent of Insurance will consult with the professions on how best to evaluate the effectiveness of this new approach and to ensure continuous quality improvements. There is also an expectation that primary health care practitioners involved in using the protocols will assess their effectiveness on an ongoing basis and provide feedback on any questions or concerns they might have to their respective professional colleges and to the Senior Medical Advisor to the Superintendent of Insurance.

Over time, changes can be made to the protocols as necessary to ensure that they provide the most appropriate level of care for patients/claimants with these injuries.

## Claims and Billing

This guide includes information about the process for claims and billings. It outlines how the process works, important timelines and the actual claims forms primary health care practitioners need to use to process claims. The objective of the claims process is to provide a straightforward, step-by-step process that ensures continuity of care for patients/claimants and appropriate payment for the services provided.

Information collected through the claims process is important, not only to process claims, but also to track outcomes for patients and the effectiveness of the protocols. Primary health care practitioners will be compensated for processing claims and completing the forms.

## Privacy Statement

The enclosed *Alberta Accident Benefits Claims Forms Package* has been developed taking into account the limits on personal information collection, use and disclosure in relevant federal and provincial privacy legislation (i.e. HIA, PIPA, PIPEDA and FOIPP).

Relevant and necessary information about your patients/claimants will be collected, used or disclosed only with the individual's consent. Statistical information concerning these individuals will be provided to the Insurance Bureau of Canada for analysis and further dissemination. The business contact information you provide as a primary health care practitioner will be used to facilitate communication with you as necessary.

If you have any questions about the collection of your or your patient's personal information, please contact the Senior Medical Advisor to Superintendent of Insurance at [larry.ohlhauser@gov.ab.ca](mailto:larry.ohlhauser@gov.ab.ca).

## For more information

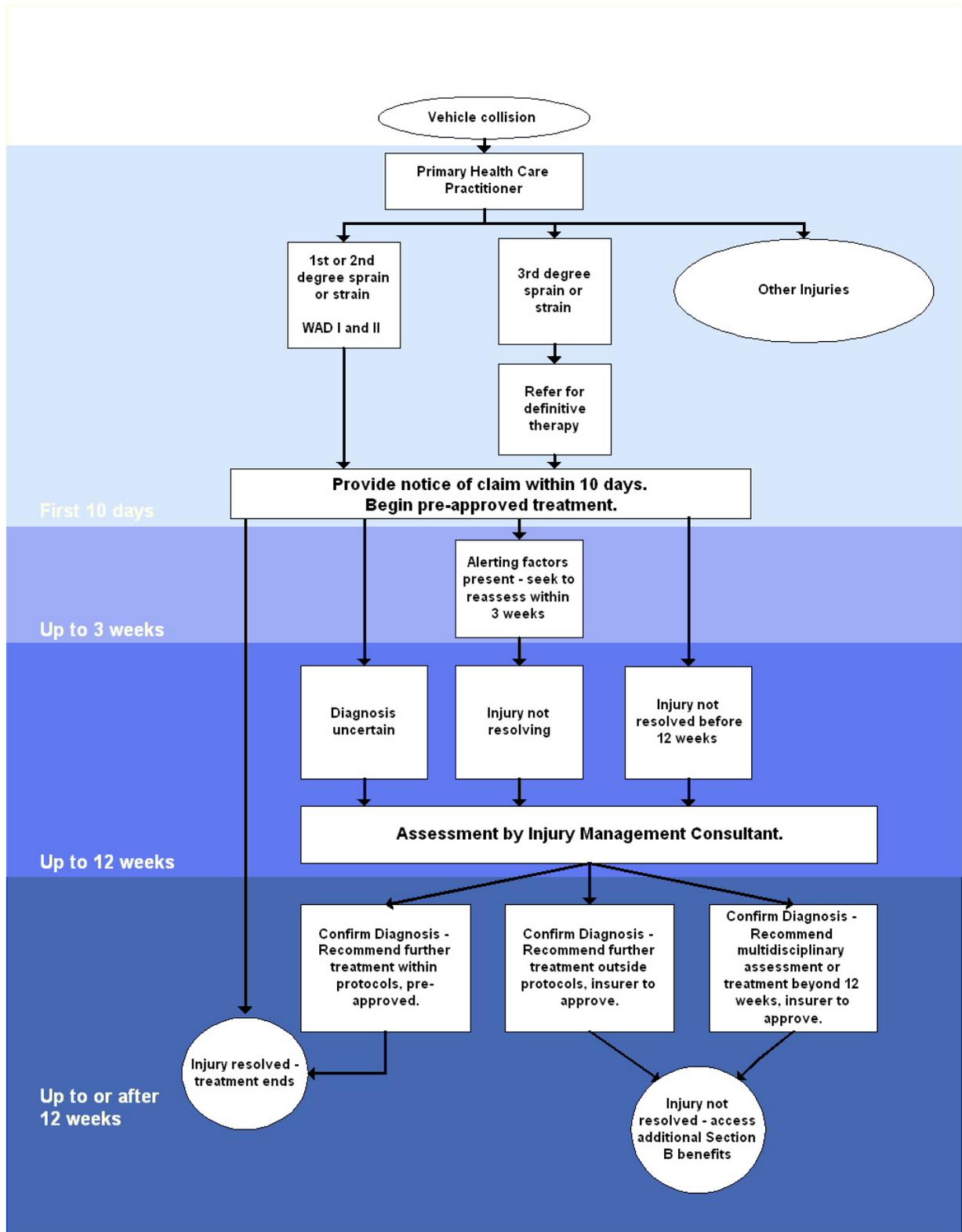
In addition to this guide, a brochure is available for patients/claimants. Copies of the brochure are available for use and distribution in your office.

Additional information is also available at [www.autoinsurance.gov.ab.ca](http://www.autoinsurance.gov.ab.ca). The web site provides further information on diagnosis and treatment of minor injuries, patient/claimant information, claims information and related documents.

If you have questions about any aspect of this guide or the diagnostic and treatment protocols, please contact:

Dr. Larry Ohlhauser  
Senior Medical Advisor to the Superintendent of Insurance  
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# FLOWCHART OF INJURY TREATMENT AND CLAIMS PROCESS



# Diagnostic and Treatment Protocols



October 1, 2004

# Strains and Sprains

## DIAGNOSIS

1. Collect the patient/claimant's history including the mechanism of injury, the current symptoms the patient/claimant is experiencing, the patient/claimant's relevant past history, including physical, psychological, emotional, cognitive and social history and how the patient/claimant's physical functions have been affected by the injury.
2. Conduct a general examination, a relevant regional examination, including an examination of the neurological and musculoskeletal system and an assessment of the pain associated with the injury.
3. Conduct and/or review the findings from any ancillary investigation including, as required, diagnostic imaging, laboratory testing, and specialized testing.
4. Identify as best as possible the muscle(s), ligament(s) or tendon(s) injured if a sprain or strain is diagnosed, and assess the degree of the strain or sprain (see Appendices A and B – Degrees of Strain and Sprain for further guidance).
5. Reference the ICD-10-CA Handbook to include a diagnostic code (See Appendix F).

## TREATMENT

1. Educate the patient/claimant with respect to at least the following matters:
  - the desirability of an early return to normal activities and to work, if applicable
  - an estimate of the probable length of time that symptoms will last
2. Manage inflammation and pain as required.
3. Teach the patient/claimant about maintaining flexibility, balance, strength and the functions of the injured area.
4. Advise the patient/claimant about self-care and the disadvantage of extended dependence on health care providers.
5. Provide other adjunct therapy that, in your opinion, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the patient/claimant.
6. Treatments that are authorized for payment and do not require prior approval from the insurer include:
  - necessary diagnostic imaging, laboratory testing and specialized testing
  - necessary medication to manage the pain
  - acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury
  - for a 1<sup>st</sup> or 2<sup>nd</sup> degree strain/sprain, not more than a combined total of 10 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment
  - for a 3<sup>rd</sup> degree strain/sprain, a combined total of 21 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment

# Whiplash-Associated Disorders (WAD) Injuries

## DIAGNOSIS

1. Collect the patient/claimant's history including the mechanism of injury, the current symptoms the patient/claimant is experiencing, the patient/claimant's relevant past history, including physical, psychological, emotional, cognitive and social history and how the patient/claimant's physical functions have been affected by the injury.
2. Conduct a general examination, a relevant regional examination, including an examination of the neurological and musculoskeletal system and an assessment of the pain associated with the injury.
3. Conduct and/or review the findings from any ancillary investigation including, as required, diagnostic imaging, laboratory testing, and specialized testing.
4. Grade the whiplash-associated disorder (WAD injury). See Appendix C for criteria for grading and diagnosing WAD injuries and Appendix D for further information about the Canadian C-Spine Rule.
5. If a WAD I injury is diagnosed, no further investigation of the injury is warranted, unless there is specific cause cited to do so.
6. An investigation to determine a WAD II injury and to rule out a more severe whiplash injury may include:
  - for cervical spine injuries, radiographic series in accordance with The Canadian C-Spine Rule for Radiography in Alert and Stable Trauma Patients. (A summary of the C-Spine Rule is included in Appendix D)
  - for thoracic and lumbosacral spine injuries, radiographic series appropriate to the region of the spine that is injured, if the patient/claimant has one or more of the following characteristics:
    - a clinical indication of bone injury
    - a clinical indication of significant degenerative changes or instability
    - a history of rheumatoid arthritis
    - a history of osteoporosis or
    - a history of cancer
7. The use of magnetic resonance imaging or computerized tomography is not authorized for payment under these protocols, unless three plain view films are equivocal.
8. Reference the ICD-10-CA Handbook to include a diagnostic code (see Appendix F).

## TREATMENT

1. Educate the patient/claimant about at least the following matters:
  - the desirability of an early return to normal activities and to work, if applicable
  - an estimate of the probable length of time that symptoms will last
  - reassurance that there is likely no serious currently detectable underlying cause of the pain, if applicable
  - the importance of postural and body mechanics control
  - the use of a soft collar is not advised
  - probable factors that are responsible for other symptoms the patient/claimant may be experiencing, including disturbance of balance, disturbance or loss of hearing, limb pain or numbness, cognitive dysfunction and jaw pain. The patient/claimant should be advised that these symptoms are temporary in nature and may not reflect tissue damage, if so determined.
2. Manage pain as required.
3. Teach the patient/claimant about maintaining flexibility, balance, strength and the functions of the injured area.
4. Provide advice about self-management and the disadvantage of extended dependence on health care providers.
5. Provide other adjunct therapy that, in your opinion, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the patient/claimant.
6. Treatments that are authorized for payment and do not require prior approval from the insurer include:
  - for a WAD I or II injury, one visit to a primary health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required. This visit is in addition to the visits for treatment indicated below.
  - necessary diagnostic imaging, laboratory testing and specialized testing
  - necessary medication to manage the pain
  - acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury
  - for a WAD I injury, not more than a combined total of 10 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment
  - for a WAD II injury, not more than a combined total of 21 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment

7. Identify alerting factors.

If a patient/claimant is diagnosed with a WAD I or WAD II injury and the patient/claimant has any alerting characteristics that may influence prognosis (see Appendix E), the primary health care practitioner must seek to reassess the patient/claimant within 21 days of the collision and, if the injury is not resolving, refer the patient/claimant to an injury management consultant for an assessment and report.

## Referral To Injury Management Consultant

A primary health care practitioner may refer the patient/claimant to an injury management consultant if the primary health care practitioner:

1. is uncertain about an injury to which the protocols apply or the diagnosis or treatment of the injury
2. believes that the injury
  - is not resolving appropriately or
  - is not resolving within the time expected and the practitioner requires another opinion

See Appendix G for a copy of the Injury Management Consultant Referral Form.

The injury management consultant will:

1. Review all relevant information regarding the injury
2. Examine the patient/claimant with reference to the diagnosis and treatment protocols
3. Provide advice and a report about the diagnosis or treatment of the patient/claimant or
4. Recommend a further assessment or a multi-disciplinary assessment of the injury or an aspect of the injury and the persons who should be included in that assessment.

## Appendix A — Degrees of Strain

	<b>1st degree strain</b>	<b>2nd degree strain</b>	<b>3rd degree strain</b>
Definition of the degree of strain	Few fibres of muscle torn	About half of muscle fibres torn	All muscle fibres torn (rupture)
Mechanism of injury	Overstretch Overload	Overstretch Overload Crushing	Overstretch Overload Crushing
Onset	Acute	Acute	Acute
Weakness	Minor	Moderate to major (reflex inhibition)	Moderate to major
Disability	Minor	Moderate	Major
Muscle spasm	Minor	Moderate to major	Major
Swelling	Minor	Moderate to major	Moderate to major
Loss of function	Minor	Moderate to major	Major (reflex inhibition)
Pain on isometric contraction	Minor	Moderate to major	None to minor
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal
Palpable defect	No	No	Yes (if detected early)
Range of motion	Decreased	Decreased	May increase or decrease depending on swelling

Extracted from *Orthopaedic Physical Assessment* by David J. Magee, (3rd), (1997), pg 19, with permission from Elsevier Inc.

## Appendix B — Degrees of Sprain

	<b>1st degree sprain</b>	<b>2nd degree sprain</b>	<b>3rd degree sprain</b>
Definition of the degree of sprain	Few fibres of ligament torn (partial tear, no instability or opening of the joint)	About half of ligament torn (partial tear with some instability indicated by partial opening of the joint on stress manoeuvres)	All fibres of ligament torn (complete tear with complete opening of the joint on stress manoeuvres)
Mechanism of injury	Overstretch Overload	Overstretch Overload	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Minor to moderate	Minor to moderate
Disability	Minor	Moderate	Moderate to major
Muscle spasm	Minor	Minor	Minor
Swelling	Minor	Moderate	Moderate to major
Loss of function	Minor	Moderate to major	Moderate to major (instability)
Pain on isometric contraction	None	None	None
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal to excessive
Palpable defect	No	No	Yes
Range of Motion	Decreased	Decreased	May increase or decrease depending on swelling. Dislocation or subluxation possible

Extracted from *Orthopaedic Physical Assessment* by David J. Magee, (3rd), (1997), pg 19, with permission from Elsevier Inc.

## Appendix C — Grading and Diagnosis of Whiplash Associated Disorders (WAD)\*

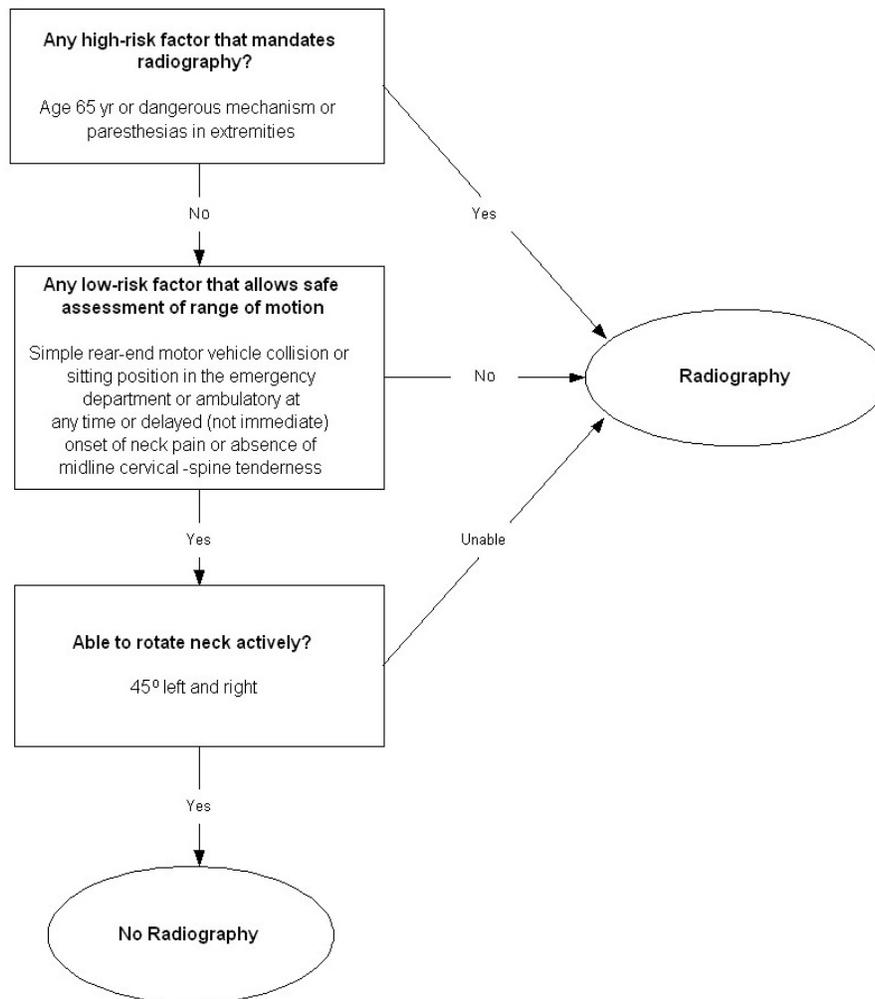
1. WAD I criteria:
  - symptoms of spinal pain, stiffness or tenderness
  - no demonstrable, definable and clinically relevant physical signs of injury
  - no tenderness and normal range of motion
  - normal reflexes and muscle strength in the limbs
  - no objective, demonstrable, definable and clinically relevant neurological signs of injury
  - no fractures to or dislocation of the spine
2. 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
3. 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 (typically due to disc protrusion)
  - no fracture to or dislocation of the spine
4. 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
5. Other injuries (specify):
6. Other important medical conditions (including drug allergies)

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\* All terms are made with reference to the *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders: Redefining "Whiplash" and Its Management*, published by Hagerstown, MD: J.B. Lippincott Company, 1995 and the *Diagnostic and Treatment Protocols Regulation*, where appropriate.

## Appendix D — Canadian C-Spine Rule

“For patients with trauma who are alert (as indicated by the score of 15 on the Glasgow Coma Scale) and in stable condition and in who cervical-spine injury is a concern, the determination of risk factors guides the use of cervical-spine radiography. A dangerous mechanism is considered to be a fall from an elevation of  $\geq$  three feet or five stairs; an axial load to the head (e.g., diving); a motor vehicle collision at high speed (greater than 100 km/hr) or with rollover or ejection; a collision involving a motorized recreational vehicle; or a bicycle collision. A simple rear-end motor collision excludes being pushed into oncoming traffic, being hit by a bus or a large truck, a rollover, and being hit by a high-speed vehicle.” (Excerpted from *The Canadian C-Spine Rule for Radiography in Alert and Stable Trauma Patients*, published in the *Journal of the American Medical Association*, October 17, 2001 – Volume 286, No.15.)



## Appendix E — Alerting Factors

If a patient/claimant is diagnosed with a WAD I or WAD II injury and the patient/claimant has any alerting characteristics that may influence prognosis (see below), the primary health care practitioner must seek to reassess the patient/claimant within 21 days of the collision and, if the injury is not resolving, refer the patient/claimant to an injury management consultant for an assessment and report.

Alerting factors for Grade I and II WAD (factors repeatedly shown to be associated with delayed healing) include:

- Age greater than 40
- Female
- More intense baseline neck or back pain
- More intense baseline headache
- The presence of baseline radicular symptoms
- The presence of depressive or other significant emotional distress symptoms within the early weeks

## Appendix F — International Classification of Disease (ICD-10-CA) Handbook

### ***What is ICD-10?***

The *International Statistical Classification of Diseases and Related Health Problems - Tenth Revision* is the most recent revision of an international core classification of diseases, injuries, and causes of death. The *World Health Organization (WHO)* is responsible for maintaining and revising ICD-10. Over time, the use of ICD has expanded. It is now used by many countries in hospitals, doctors' offices and health care facilities to record non-fatal diseases, symptoms and other conditions necessitating contact with health care providers for medical services.

### ***What is ICD-10-CA?***

With the approval of Health Canada, the Canadian Institute for Health Information (CIHI) has received permission to enhance the international classification to meet Canadian needs within the requirements of its licence agreement with WHO.

### ***ICD-10-CA Code List***

The following list is a sub-set of ICD-10-CA (2003) codes. ***It neither endorses nor precludes the use of any ICD-10-CA code.*** Codes should be selected based upon the guidance from provider associations, the appropriateness of a specific code for a particular clinical situation, and guidelines provided by the Canadian Institute for Health Information.

The ICD-10-CA Injury Codes are only required for the completion of the Notice of Loss and Proof of Claim Form (Form AB-1) and the Treatment Plan (Form AB-2) for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

If you require further assistance, please contact the Senior Medical Advisor to the Superintendent of Insurance at [larry.ohlhauser@gov.ab.ca](mailto:larry.ohlhauser@gov.ab.ca).

**CODE**                      **INJURY DESCRIPTION**

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF HEAD*

S03.0	Dislocation of jaw
S03.3	Dislocation of other and unspecified parts of head
S03.4	Sprain and strain of jaw
S03.5	Sprain and strain of joints and ligaments of other and unspecified parts of head

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS AT NECK LEVEL*

S13.1	Dislocation of cervical vertebra
S13.2	Dislocation of other and unspecified parts of neck
S13.3	Multiple dislocations of neck
S13.40	Whiplash Associated Disorder (WAD 1) with complaint of neck pain, stiffness or tenderness (Whiplash NOS, No Physical Signs)
S13.41	Whiplash Associated Disorder (WAD 2) with complaint of neck pain with musculoskeletal signs (decreased ranged of motion and point tenderness)
S13.42	Whiplash Associated Disorder (WAD 3) with complaint of neck pain with neurological signs (decreased or absent deep tendon reflexes, weakness and sensory deficits)
S13.48	Other sprain and strain of cervical spine
S13.5	Sprain and strain of thyroid region
S13.6	Sprain and strain of joints and ligaments of other and unspecified parts of neck

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF THORAX*

S23.0	Traumatic rupture of thoracic intervertebral disc
S23.1	Dislocation of thoracic vertebra
S23.2	Dislocation of other and unspecified parts of thorax
S23.3	Sprain and strain of thoracic spine
S23.4	Sprain and strain of ribs and sternum
S23.5	Sprain and strain of other and unspecified parts of thorax

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF LUMBAR SPINE AND PELVIS*

S33.0	Traumatic rupture of lumbar intervertebral disc
S33.1	Dislocation of lumbar vertebra
S33.2	Dislocation of sacroiliac and sacrococcygeal joint
S33.3	Dislocation of other and unspecified parts of lumbar spine and pelvis
S33.4	Traumatic rupture of symphysis pubis
S33.5	Sprain and strain of lumbar spine
S33.6	Sprain and strain of sacroiliac joint
S33.7	Sprain and strain of other and unspecified parts of lumbar spine and pelvis

<b>CODE</b>	<b>INJURY DESCRIPTION</b>
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*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF SHOULDER GIRDLE*

S43.00	Anterior dislocation of shoulder
S43.01	Posterior dislocation of humerus
S43.02	Inferior dislocation of humerus
S43.09	Unspecified dislocation of glenohumeral joint
S43.1	Dislocation of acromioclavicular joint
S43.2	Dislocation of sternoclavicular joint
43.38	Dislocation of other parts of shoulder girdle
S43.39	Dislocation of unspecified part of shoulder girdle
S43.400	Sprain and strain of shoulder joint, coracohumeral joint
S43.401	Sprain and strain of shoulder joint, rotator cuff (capsule)
S43.5	Sprain and strain of acromioclavicular joint
S43.6	Sprain and strain of sternoclavicular joint
S43.70	Sprain and strain of other and unspecified parts of shoulder girdle, coracoclavicular joint (ligament)
S43.71	Sprain and strain of other and unspecified parts of shoulder girdle, infraspinatus (muscle) (tendon)
S43.72	Sprain and strain of other and unspecified parts of shoulder girdle, subscapularis (muscle)
S43.73	Sprain and strain of other and unspecified parts of shoulder girdle, supraspinatus (muscle)
S43.78	Sprain and strain of other parts of shoulder girdle
S43.79	Sprain and strain of unspecified part of shoulder girdle

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF ELBOW*

S53.0	Dislocation of radial head
S53.10	Anterior dislocation of elbow
S53.11	Posterior dislocation of elbow
S53.12	Medial dislocation of elbow
S53.13	Lateral dislocation of elbow
S53.18	Other dislocation of elbow
S53.19	Unspecified dislocation of elbow
S53.2	Traumatic rupture of radial collateral ligament
S53.3	Traumatic rupture of ulnar collateral ligament
S53.40	Sprain and strain of radial collateral ligament
S53.41	Sprain and strain of ulnar collateral ligament
S53.42	Sprain and strain of radiohumeral (joint)
S53.43	Sprain and strain of ulnohumeral (joint)
S53.48	Other sprain and strain of elbow
S53.49	Unspecified sprain and strain of elbow

**CODE**                      **INJURY DESCRIPTION**

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS AT WRIST AND HAND LEVEL*

S63.00	Dislocation of radioulnar (joint) distal
S63.01	Dislocation of radiocarpal (joint)
S63.02	Dislocation of midcarpal (joint)
S63.03	Dislocation of carpometacarpal (joint)
S63.04	Dislocation of metacarpal (bone) proximal end
S63.08	Other dislocation of wrist
S63.09	Unspecified dislocation of wrist
S63.10	Dislocation of metacarpophalangeal (joint) of finger
S63.11	Dislocation of interphalangeal (joint) of finger
S63.18	Other dislocation of finger
S63.19	Unspecified dislocation of finger
S63.2	Multiple dislocations of fingers
S63.3	Traumatic rupture of ligament of wrist and carpus
S63.4	Traumatic rupture of ligament of finger at metacarpophalangeal and interphalangeal joint(s)
S63.50	Sprain and strain of carpal (joint) of wrist
S63.51	Sprain and strain of radiocarpal (joint)(ligament) of wrist
S63.58	Other sprain and strain of wrist
S63.59	Unspecified sprain and strain of wrist
S63.60	Sprain and strain of interphalangeal (joint) of finger(s)
S63.61	Sprain and strain of metacarpophalangeal (joint) of finger(s)
S63.68	Other sprain and strain of finger(s)
S63.69	Unspecified sprain and strain of finger(s)
S63.70	Sprain and strain of carpometacarpal (joint) of hand
S63.71	Sprain and strain of metacarpal (distal) (proximal)
S63.72	Midcarpal sprain and strain of hand
S63.78	Sprain and strain of other parts of hand
S63.79	Sprain and strain of unspecified parts of hand

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF HIP*

S73.00	Posterior dislocation of hip
S73.01	Obturator dislocation of hip
S73.08	Other anterior dislocation of hip
S73.09	Unspecified dislocation of hip
S73.10	Sprain and strain of iliofemoral ligament
S73.11	Sprain and strain of ischiocapsular ligament
S73.18	Sprain and strain of other specified sites of hip
S73.19	Sprain and strain of unspecified site of hip

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF KNEE*

S83.0	Dislocation of patella
S83.10	Anterior dislocation of knee
S83.11	Posterior dislocation of knee
S83.12	Medial dislocation of knee
S83.13	Lateral dislocation of knee

*List continued on the following page...*

**CODE****INJURY DESCRIPTION***DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS OF KNEE (continued)*

S83.18	Other dislocation of knee
S83.19	Unspecified dislocation of knee
S83.20	Tear of medial cartilage or meniscus of knee, current
S83.21	Tear of lateral cartilage or meniscus of knee, current
S83.3	Tear of articular cartilage of knee, current
S83.400	Sprain and strain of lateral collateral ligament of knee, rupture
S83.401	Other sprain and strain of lateral collateral ligament of knee
S83.410	Sprain and strain of medial collateral ligament of knee, rupture
S83.411	Other sprain and strain of medial collateral ligament of knee
S83.480	Sprain and strain of other collateral ligament of knee, rupture
S83.481	Other sprain and strain of other collateral ligament of knee
S83.490	Sprain and strain of unspecified collateral ligament of knee, rupture
S83.491	Other sprain and strain of unspecified collateral ligament of knee
S83.500	Sprain and strain of anterior cruciate ligament of knee, rupture
S83.501	Other sprain and strain of anterior cruciate ligament of knee
S83.510	Sprain and strain of posterior cruciate ligament of knee, rupture
S83.511	Other sprain and strain of posterior cruciate ligament of knee
S83.580	Sprain and strain of other cruciate ligaments of knee, rupture
S83.581	Other sprain and strain of other cruciate ligaments of knee
S83.590	Sprain and strain of unspecified cruciate ligament of knee, rupture
S83.591	Other sprain and strain of unspecified cruciate ligament of knee
S83.6	Sprain and strain of other and unspecified parts of knee
S83.7	Injury to multiple structures of knee

*DISLOCATION, SPRAIN AND STRAIN OF JOINTS AND LIGAMENTS AT ANKLE AND FOOT LEVEL*

S93.0	Dislocation of ankle joint
S93.10	Dislocation of metatarsophalangeal joint
S93.11	Dislocation of (interphalangeal) joint of toe
S93.2	Rupture of ligaments at ankle and foot level
S93.30	Dislocation of tarsal (midtarsal) joint
S93.31	Dislocation of tarsometatarsal joint
S93.40	Sprain and strain of deltoid ligament, ankle
S93.41	Sprain and strain of calcaneofibular ligament, ankle
S93.42	Sprain and strain of distal tibiofibular ligament, ankle
S93.48	Sprain and strain of other ligament of ankle
S93.50	Sprain and strain of metatarsophalangeal joint
S93.51	Sprain and strain of (interphalangeal) joint of toe
S93.6	Sprain and strain of other and unspecified parts of foot

# Patient Information Examples



October 1, 2004

# Patient Check List for Whiplash-Associated Disorders (example # 1)

This data check list is intended as a guide to the assessment and treatment of a whiplash patient/claimant with Grade I or Grade II WAD injuries. The checklist is not an exhaustive list and does not take into consideration any non-WAD injuries.

## History (PATIENT/CLAIMANT TO COMPLETE)

### 1. Symptom Checklist

For each symptom, check YES (if present) or NO (if not present), and rate severity on a scale of 0 to 10 where indicated 0 is “No Pain” and 10 is “pain as bad as it could be.”

<i>Neck or shoulder pain</i>				<input type="checkbox"/> YES	<input type="checkbox"/> NO			Pain as Bad as Could Be	
No Pain									
0	1	2	3	4	5	6	7	8	9 10

<i>Upper or Mid-back pain</i>				<input type="checkbox"/> YES	<input type="checkbox"/> NO			Pain as Bad as Could Be	
No Pain									
0	1	2	3	4	5	6	7	8	9 10

<i>Low back pain</i>				<input type="checkbox"/> YES	<input type="checkbox"/> NO			Pain as Bad as Could Be	
No Pain									
0	1	2	3	4	5	6	7	8	9 10

<i>Headache</i>				<input type="checkbox"/> YES	<input type="checkbox"/> NO			Pain as Bad as Could Be	
No Pain									
0	1	2	3	4	5	6	7	8	9 10

<i>Pain in Arm(s)</i>				<input type="checkbox"/> YES	<input type="checkbox"/> NO			Pain as Bad as Could Be	
No Pain									
0	1	2	3	4	5	6	7	8	9 10

***Pain in Hand(s)***                       YES                       NO

No Pain                      0                      1                      2                      3                      4                      5                      6                      7                      8                      Pain as Bad as Could Be 9                      10

***Pain in Face or Jaw***                       YES                       NO

No Pain                      0                      1                      2                      3                      4                      5                      6                      7                      8                      Pain as Bad as Could Be 9                      10

***Pain in Leg(s)***                       YES                       NO

No Pain                      0                      1                      2                      3                      4                      5                      6                      7                      8                      Pain as Bad as Could Be 9                      10

***Pain in Foot/Feet***                       YES                       NO

No Pain                      0                      1                      2                      3                      4                      5                      6                      7                      8                      Pain as Bad as Could Be 9                      10

***Pain in Abdomen or Chest***                       YES                       NO

No Pain                      0                      1                      2                      3                      4                      5                      6                      7                      8                      Pain as Bad as Could Be 9                      10

***Feeling of numbness, tingling in arms or hands***                       YES                       NO

***Feeling of numbness, tingling in legs or feet***                       YES                       NO

***Dizziness or unsteadiness***                       YES                       NO

***Vision problems***                       YES                       NO

***Hearing problems***                       YES                       NO

***Anxiety or worry***                       YES                       NO

***Nausea or vomiting***                       YES                       NO

***Difficulty swallowing***                       YES                       NO

*Problems concentrating or with memory*             YES             NO

2. *Loss of consciousness*                             YES             NO

3. *Have the injuries prevented you from carrying out any of the following:*

- Daily home activities (Ask patient/claimant to explain)
- Employment (Ask patient/claimant to explain)
- Schooling (Ask patient/claimant to explain)
- Sports or recreation
- Other (Ask patient/claimant to explain)

4. *Do you think your injury will:*

- get better soon
- get better slowly
- never get better
- don't know

## Patient/claimant Education (Example # 2)

One of the key aspects of the protocols is the emphasis on patient/claimant education. The following is an example of the kind of information and education you could provide to a patient/claimant with a grade I or II whiplash injury when appropriate.

*To the patient/claimant:*

1. On the basis of your symptoms and the examination, you have grade I (or II) whiplash. This means most likely that you have a sprain of muscles and ligaments and that you do not have a fracture, injury to nerves, or other serious damage that we can detect.
2. The symptoms you are experiencing are normal and common for your type of injury. Most people recover from this injury within 6 weeks, and you should have no long term problems. It is rare that people have chronic pain and trouble working or enjoying their usual lifestyle after the injury. There are things you can do to help reduce the chance of this happening. And there are other things you may do that will increase the chance of chronic pain happening. As long as you focus on what you can do to recover, you will do well.
3. It is important to maintain normal activities or modified activities as much as possible. At first, these activities might be painful, but evidence suggests that resuming normal activities will help improve your recovery. There is no evidence that normal activities, even though they may hurt, will cause any long-term harm.
4. Start with exercise and good posture maintenance early. Whiplash patients/claimants who exercise daily despite the fact that these exercises may hurt initially do better than those who rest and hope the pain will go away on its own.
5. Avoid using a collar. While collars may offer temporary relief, using a collar actually prolongs recovery.
6. Avoid relying solely on non-exercise (passive) therapies. In general, whiplash patients/claimants who use these types of passive therapies instead of exercise, or people who have an expectation that others will cure them, do not do well. The best approach with the best chance of recovery is to exercise daily.
7. Do not rely on medications to completely eliminate pain. There is no evidence that medications speed recovery from whiplash injury. Medications may help in the short term if they ease the pain and allow people to keep active and exercise regularly. Over-the-counter medications are known to be the safest and should be used first. Other pain killers and medications cause many side effects including sedation, dizziness, dry mouth, poor concentration, poor memory, ringing in the ears, visual disturbance, and headache.

8. Although it may be difficult, paying too close attention and continually worrying about the symptoms will, in fact, make the symptoms more severe. The same is true for talking with friends and family members about the amount of pain. The best approach is to try to relax, carry on with normal activities, exercise appropriately and understand that it might take some time, but the pain will go away.
9. Aches and pains, headaches and many other symptoms are common in life, especially if life becomes stressed. Don't necessarily assume that problems noticed months later are caused by the injury. It is natural for people to pay closer attention to their bodies after an injury. The best distraction from pain and the natural tendency to pay more attention to symptoms is to continue normal, everyday activities despite the hurt, keep a regular schedule, and keep stress levels down.

# Claims and Billing Information



October 1, 2004

## General Claims Information

Alberta residents who are an occupant of a vehicle involved in a motor vehicle accident have Accident Benefits Insurance Coverage regardless of whether they were at fault for the collision. To claim these benefits, the patient/claimant will require the assistance of their insurance adjuster and a primary health care practitioner (medical doctor, chiropractor or physical therapist).

This section outlines the administrative process for the patient/claimant, primary health care practitioners and insurers. The claims process is designed to provide a streamlined, step-by-step approach where one step flows smoothly to the next and the patient/claimant gets the continuity of service and treatment they need, consistent with the diagnosis and treatment protocols when applicable. As part of the process, primary health care practitioners will be compensated for completing the necessary claim forms.

If you have any questions, please contact either the claims adjuster for your patient/claimant, or for more information the Government of Alberta at [www.autoinsurance.gov.ab.ca](http://www.autoinsurance.gov.ab.ca).

If you are having difficulty contacting the claims adjuster for your patient/claimant please refer to the following website at [www.abc.ca](http://www.abc.ca) and click on Alberta Auto Insurance Reform or you can contact the Insurance Bureau of Canada at 1-800-377-6378.

## Claims Timelines and Responsibilities

Timelines	Responsibilities
<p><b>0 to 10 business days following the collision</b></p>	<ul style="list-style-type: none"> <li>▪ Assess and diagnose the patient/claimant according to the protocols, if applicable.</li> <li>▪ Assist the patient/claimant in completing the Notice of Loss and Proof of Claim Form (Form AB-1). This form must be completed and submitted to the insurer within 10 business days of the collision or as soon as practicable.</li> <li>▪ The practitioner providing ongoing treatment of the patient/claimant should complete the Treatment Plan (Form AB-2) if the injury includes a sprain, strain or WAD (I or II).</li> <li>▪ If necessary, inform the insurer (Form AB-2 and AB-2a) that you may require authorization to use goods and services not included in the protocols (i.e., psychological care, occupational therapy, nursing, dental care).</li> <li>▪ If it is likely that the patient/claimant will be disabled for a period of time and is likely to lose income, the claimant may ask you to assist them to complete a claim for disability benefits (Form AB-1a).</li> </ul>

Timelines	Responsibilities
<p><b>Within 5 business days after the Notice of Loss and Proof of Claim Form (Form AB-1) has been submitted (5 – 15 days following the collision)</b></p>	<ul style="list-style-type: none"> <li>▪ Contact the insurer to confirm approval of the claim and obtain contact information of the insurance claims adjuster.</li> <li>▪ If the claim is approved, continue to educate and reassure the patient/claimant and provide treatment within limits of the protocols.</li> <li>▪ If the claim is refused, the claims representative will honour treatment expenses incurred to the point of refusal.</li> </ul>
<p><b>5 to 21 days post-injury</b></p>	<ul style="list-style-type: none"> <li>▪ For WAD I or WAD II patients/claimants, seek to reassess the patient/claimant within 21 days if any alerting factors were present at the initial examination.</li> <li>▪ If the injury is not resolving, a primary health care practitioner may authorize a visit by the patient/claimant to an Injury Management Consultant for an assessment and report.</li> </ul>
<p><b>15 to 90 days post-collision and before completion of 10 or 21 treatments</b></p>	<ul style="list-style-type: none"> <li>▪ Maintain contact with insurer regarding the patient/claimant’s progress if requested by the insurer. Provide progress and discharge reports as appropriate to the insurer (Forms AB-3 and AB-4, respectively).</li> <li>▪ Prior to completion of treatments, notify the claims representative of the need for either additional services or a referral to an Injury Management Consultant if the patient/claimant’s injury is not resolving satisfactorily. A copy of the referral form (Form AB-5) should be provided to the insurer and the IMC.</li> <li>▪ If the patient/claimant has recovered, submit final invoice and, if required by the insurer, submit a discharge report (Forms AB-2a and AB-4, respectively).</li> </ul>
<p><b>15 to 90 days post-collision and upon completion of 10 or 21 treatments</b></p>	<ul style="list-style-type: none"> <li>▪ If the patient/claimant has recovered, submit final invoice and, if required by the insurer, submit a discharge report (Forms AB-2a and AB-4, respectively).</li> <li>▪ If the patient/claimant has not recovered, consult with insurer for authorization for payments for further services (Forms AB-3 or AB-4 could be used as applicable).</li> <li>▪ Refer patient/claimant to Injury Management Consultant (A copy of the referral form (Form AB-5) should be provided to the insurer with an explanation of the need for referral).</li> </ul> <p><b>Note: Authorization for payment under the protocols expires 90 days after the collision unless the insurer approves use of the protocols beyond 90 days</b></p>

## Claims for Injuries within the Diagnostic and Treatment Protocols

It is important to remember that, if the treatment protocols are followed:

- Insurance companies have received extensive information about the new Regulations for processing claims involving sprains, strains and WAD injuries and should be able to provide timely, accurate information to you and to your patients/claimants.
- The Notice of Loss and Proof of Claim Form (Form AB-1) must be completed and submitted to the insurer within 10 business days of the collision or as soon as practicable.
- Bill the auto insurer directly for all treatment services described in the diagnostic and treatment protocols that are not covered by Alberta Health Care Insurance (Forms AB -1, AB - 2, AB - 3 or AB - 4 and current Invoice Statements of your office).
- Obtain a signed statement from the patient/claimant verifying receipt of any services (Form 2a) that are being billed to the insurer.
- If you or your patient/claimant believes that additional treatment is required or if you are uncertain about the diagnosis, the patient/claimant can be referred to an Injury Management Consultant (Form AB - 5).
- Authorization for payment under the protocols expires 90 days after the collision unless the insurer approves use of the protocols beyond 90 days
- If, in the opinion of a primary health care practitioner, adjunct therapy is necessary for the treatment or rehabilitation of the injury and if the adjunct therapy is linked to the continued clinical improvement of the patient/claimant, the claimant may be referred to a massage therapist, acupuncturist, another primary health care practitioner, or perform the treatment themselves. Any treatment visit authorized by the primary health care practitioner will be deducted from the overall visits (10 or 21 as appropriate) and requires a signed copy of form AB-2a. The adjunct therapy provider can submit the form, with the signature of the patient/claimant, for reimbursement directly from the insurer.
- During the period in which the diagnostic and treatment protocols apply, insurers are not authorized to request a medical assessment with respect to: “*any service, diagnostic imaging, laboratory testing, specialized testing, supply, treatment, visit, therapy, assessment, making a report or other activity or function authorized under the protocols.*” However, if a patient/claimant or a health provider is seeking diagnostic and treatment services that are not covered by the protocols or once the protocols period has ended, the insurer is able to request a medical assessment with respect to those services.

## Claims for Injuries Outside the Diagnostic and Treatment Protocols

- The insurer is not required to pay expenses until the Notice of Loss and Proof of Claim Form (Form AB-1) has been received by the insurer.
- If Form AB-1 can not practicably be submitted within 30 days of the accident, the claimant or their representative should contact the insurer.
- An Insurer must pay:
  - “...**reasonable** expenses incurred within 2 years from date of accident ....for **necessary** medical, surgical, chiropractic, dental, hospital, psychological, physical therapy, occupational therapy, massage therapy, acupuncture, professional nursing and ambulance services **and, in addition**, other services and supplies that are, in the opinion of the insured person’s attending physician and in the opinion of the insurer’s medical advisor, **essential** for the treatment or rehabilitation of the insured person, to the limit of \$50,000.” This includes all expenses incurred on or behalf of the insured person in completing the medical report portion of the Notice of Loss and Proof of Claim Form (Form AB-1)
- If a patient/claimant or a health provider is seeking diagnostic and treatment services that are not covered by the protocols or once the protocols period has ended, the insurer is able to request a medical assessment with respect to those services.
- If a patient/claimant has an injury not covered by the protocols, the insurer has no right and the claimant is under no obligation to undergo a medical assessment for the following services:
  - Chiropractic services
  - Massage therapy services
  - Acupuncture services
  - The following services to the extent of the specified limit: psychological services (up to \$600 per person); physical therapy services (up to \$600 per person); and occupational therapy services (up to \$600 per person)
- However, insurers are also not required to pay more than \$750 for chiropractic services, \$250 for massage therapy or \$250 for acupuncture services. These amounts are in addition to services provided for under the protocols and Alberta Health Care Insurance.
- Primary health care practitioners need to be aware that, outside the protocols, the priority of payment rule is different from inside the protocols. Inside the protocols, the insurer is the first payer after Alberta Health Care Insurance. Outside the protocols, there is no change from the pre-October 1, 2004 rules; the auto insurer is the second payer after both extended health benefits (e.g. Blue Cross or similar employee benefit plans) and Alberta Health Care Insurance. As at October 1, 2004 this rule continues to apply to chiropractic services covered by Alberta Health Care Insurance. If a change to the rule does occur, notification will be provided on the website ([www.autoinsurance.gov.ab.ca](http://www.autoinsurance.gov.ab.ca)), and to the College of Chiropractors of Alberta.

## Compensation for Assessments, Completion of forms and Related services, inside and outside the protocols

- Automobile Insurance Accident Benefits, Alberta Health Care Insurance and the patient/claimant are each responsible for compensating the primary health care practitioner and other health service providers for certain services and supplies.
- If an expense is paid out of pocket by a patient/claimant, her or she can claim for reimbursement from the Insurer.
- The table below is a summary of which party will initially be expected to provide payment for specific services. Additional information and background is provided in the following pages and in the respective Regulations.

Service Provided	Individual or Plan to be Billed		
	Insurer	Patient/ Claimant	Alberta Health Care Insurance
<b>1. Initial Assessment of the Patient/Claimant and Completion of Form AB-1</b>			
Assessment by Medical Doctor			X
Assessment by Chiropractor or Physical Therapist	X		
Completion of Form AB-1	X		
<b>2. Completion of the Treatment Plan (Form AB-2)</b>			
Assessment by Chiropractor or Physical Therapist, if Form AB-1 completed by Medical Doctor	X		
Completion of the Treatment Plan	X		
<b>3. Fee for completion of the Progress Report or Concluding Report</b>			
Completion of the Progress Report (Form AB-3)	X		
Completion of the Concluding Report (Form AB-4)	X		
<b>4. Completion of the IMC Referral Form</b>			
Completion of the IMC Referral Form	X		
<b>5. Disability Assessment and Completion of Form (AB-1a)</b>			
Assessment by Medical Doctor			X
Completion of Claim for Disability Benefits (Form AB-1a)		X	
<b>6. Missed or Late Appointment</b>			
Missed or Late appointment		X	
<b>7. Necessary Supplies or Services</b>			
<i>Supplies to assist rehabilitation (e.g., exercise balls, tensor bandages, cold packs, etc.). Approval required from Insurer if total expected to be \$160 for WAD II or third degree sprain or strain, \$120 for WAD I, \$60 first or second degree sprain or strain, or \$160 for all sprains, strains, and WAD I or II injuries</i>	X (Inside Protocols)	X (Outside Protocols)	

**1. Initial assessment of the patient/claimant and completion of Form AB-1 (Notice of Loss and Proof of Claim Form)**

- A claimant requiring an initial assessment of his or her injury can choose to be assessed by either a medical doctor, physical therapist or chiropractor in accordance with section 9(1)(a), 13(1)(a), 18(1)(a), 21(a), 22(1)(a) and 23 of the *Diagnostic and Treatment Protocols Regulation*.
- A medical doctor shall invoice Alberta Health Care Insurance for the assessment and the insurer for completion of Form AB-1.
- A chiropractor or a physical therapist shall invoice the insurer for the assessment and completion of Form AB-1.
- In an initial assessment, if a medical doctor recommends a claimant to be further treated by a physical therapist or chiropractor, the subsequent treating physical therapist or chiropractor is entitled to an initial assessment fee and a completion of treatment plan fee to be paid by the insurer. They are not entitled to a fee for completion of Form AB-1.
- Pursuant to Section 24(2) and 22(1)(a) of the protocols, a physical therapist or a chiropractor is not entitled to a fee for the second assessment of the claimant's injury without the approval of the insurer, including the reassessment within 21 days if the patient/client exhibited any alerting factors. However, a medical doctor may apply to Alberta Health Care Insurance for reimbursement of the services he or she has provided under the schedule of medical benefits.

**2. Completion of the Treatment Plan Form (Form AB-2)**

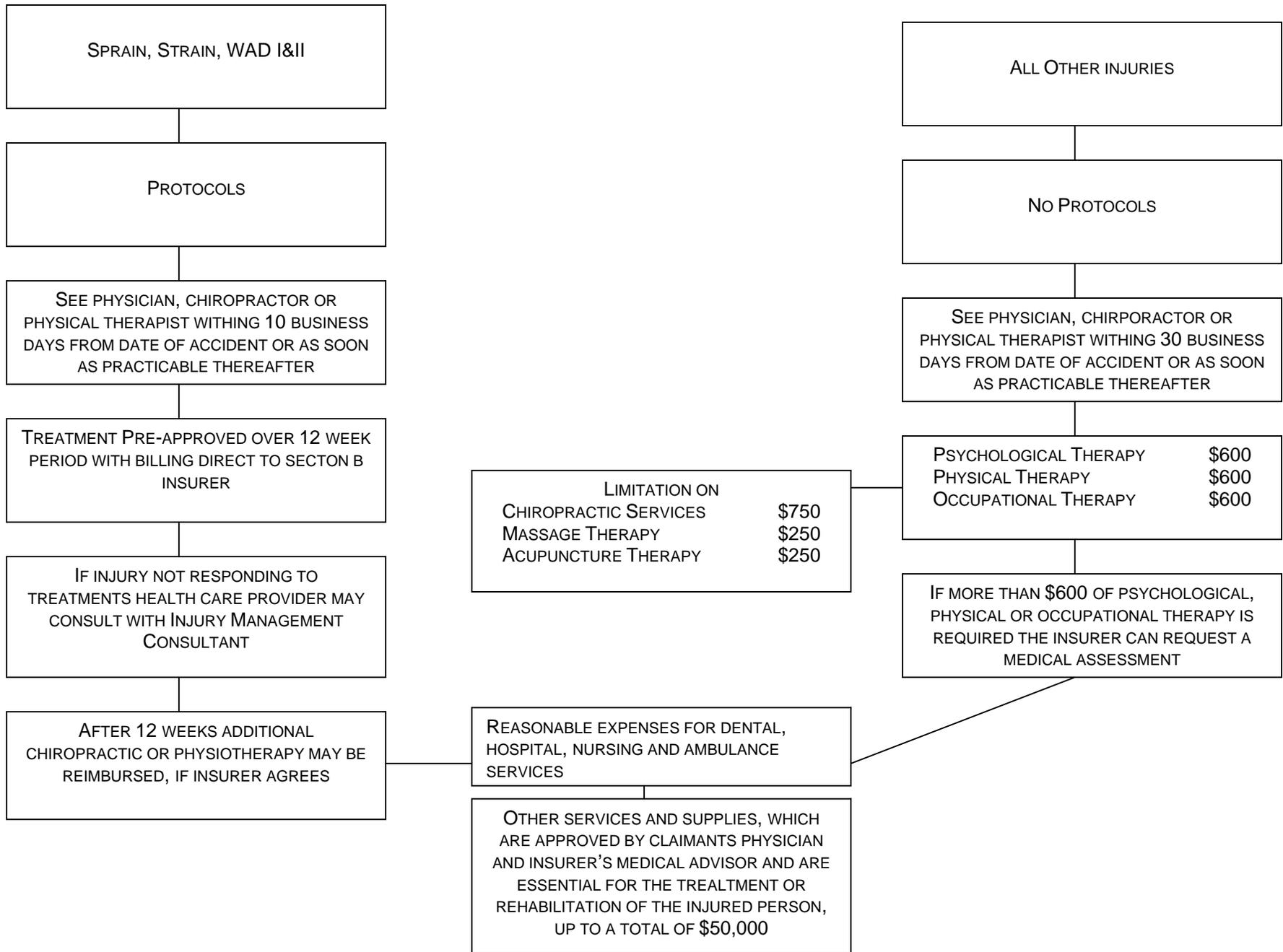
- If a physical therapist or chiropractor has invoiced the insurer for an initial assessment and completion of Form AB-1, they are not entitled to invoice the insurer for a second assessment. However, they are entitled to send an invoice to the insurer for completion of Form AB-2.
- In an initial assessment, if a medical doctor recommends a claimant to be further treated by a physical therapist or chiropractor, the subsequent treating physical therapist or chiropractor is entitled to an initial assessment fee and a completion of treatment plan fee to be paid by the insurer. They are not entitled to a fee for completion of Form AB-1.
- If a patient/claimant wishes to switch primary health care practitioners or deviate from the treatment plan they should discuss this with both the relevant primary health care practitioners and their insurer.

**3. Fee for completion of the Progress Report (Form AB-3) and the Concluding Report (Form AB-4)**

- The primary health care practitioner is entitled to invoice the insurer for the cost of completing these reports only if the insurer requests additional information about the claimant's progress.

4. Fee for completion of the Referral to an IMC (Form AB-5)
  - Pursuant to sections 24 and 25 of the protocols, a primary health care practitioner may refer a patient/claimant to an injury management consultant. Upon receipt of the completed referral form (Form AB-5), the insurer will compensate the primary health care practitioner for this service.
  - A primary health care practitioner may not invoice the insurer for a referral to another primary health care practitioner or adjunct therapy practitioner.
  - If the IMC requests additional information, the primary health care practitioner may charge a base rate plus fee per page to the insurer. After 90 days from the date of the collision, an invoice can be sent to the insurer only if the insurer has approved the assessment by the IMC.
  - Pursuant to sections 24 and 25 of the protocols, the IMC is required to issue a report and copy both the insurer and the primary health care practitioner. Upon receipt of the report, the insurer will compensate the IMC for this service.
5. Disability assessment and completion of the Claim for Disability Benefits Form AB-1a
  - A medical doctor shall invoice Alberta Health Care Insurance for the assessment and the patient/claimant for completion of Form AB-1a.
  - The insurer shall pay all expenses incurred by or on behalf of the claimant in completing the medical report portion of the prescribed claim form.
6. Missed or late appointments
  - If a patient/claimant misses an appointment or is late for an appointment, the insurer is not responsible for reimbursing the primary health care practitioner for that time. The health care practitioner may charge the patient/claimant a late or missed appointment fee.
7. Necessary supplies and services
  - Some rehabilitation programs and treatment plans may require the provision of sundry supplies, goods and services (e.g., exercise balls, tensor bandages, cold packs, etc.).
  - If the patient/claimant is being treated within the protocols, the primary health care practitioner may invoice the insurer directly for these supplies. Outside the protocols, the primary health care practitioner shall bill the patient/claimant unless some alternative arrangement has been agreed to by the claim representative.
  - The primary health care practitioner shall first obtain approval from the insurer for reimbursement of these supplies (excluding medications) if the total is expected to be greater than;
    - \$160 for WAD II and third degree sprain or strain injuries,
    - \$120 for WAD I injuries,
    - \$60 for first and second degree sprain or strain injuries, or
    - \$160 for all sprains, strains and WAD I or II injuries

# FLOWCHART OF AUTOMOBILE INSURANCE ACCIDENT BENEFITS



SPRAIN, STRAIN, WAD I&II

PROTOCOLS

SEE PHYSICIAN, CHIROPRACTOR OR PHYSICAL THERAPIST WITHING 10 BUSINESS DAYS FROM DATE OF ACCIDENT OR AS SOON AS PRACTICABLE THEREAFTER

TREATMENT PRE-APPROVED OVER 12 WEEK PERIOD WITH BILLING DIRECT TO SECTON B INSURER

IF INJURY NOT RESPONDING TO TREATMENTS HEALTH CARE PROVIDER MAY CONSULT WITH INJURY MANAGEMENT CONSULTANT

AFTER 12 WEEKS ADDITIONAL CHIROPRACTIC OR PHYSIOTHERAPY MAY BE REIMBURSED, IF INSURER AGREES

LIMITATION ON  
CHIROPRACTIC SERVICES \$750  
MESSAGE THERAPY \$250  
ACUPUNCTURE THERAPY \$250

REASONABLE EXPENSES FOR DENTAL, HOSPITAL, NURSING AND AMBULANCE SERVICES

OTHER SERVICES AND SUPPLIES, WHICH ARE APPROVED BY CLAIMANTS PHYSICIAN AND INSURER'S MEDICAL ADVISOR AND ARE ESSENTIAL FOR THE TREATMENT OR REHABILITATION OF THE INJURED PERSON, UP TO A TOTAL OF \$50,000

ALL OTHER INJURIES

NO PROTOCOLS

SEE PHYSICIAN, CHIRPORACTOR OR PHYSICAL THERAPIST WITHING 30 BUSINESS DAYS FROM DATE OF ACCIDENT OR AS SOON AS PRACTICABLE THEREAFTER

PSYCHOLOGICAL THERAPY	\$600
PHYSICAL THERAPY	\$600
OCCUPATIONAL THERAPY	\$600

IF MORE THAN \$600 OF PSYCHOLOGICAL, PHYSICAL OR OCCUPATIONAL THERAPY IS REQUIRED THE INSURER CAN REQUEST A MEDICAL ASSESSMENT

## Appendix G — Prescribed Forms

AB - 1	Notice of Loss & Proof of Claim Form
AB – 1a	Claim for Disability Benefits
AB - 2	Treatment Plan
AB – 2a	Confirmation of Services Provided
AB - 3	Progress Report
AB - 4	Concluding Report
AB - 5	Referral Report Form

Form AB-1 — Notice of Loss and Proof of Claim Form

## ALBERTA ACCIDENT BENEFITS CLAIMS FORMS PACKAGE

*Use this package to claim for benefits if you were injured in an automobile accident on or after October 1, 2004. Please note that all automobile accidents involving bodily injury are required to be reported to the police.*

**There are 4 forms in this package:**

### **Notice of Loss & Proof of Claim Form (Form AB-1)**

Fill out this form when you are claiming for benefits **for the first time**, as a result of an accident, including if you are injured and are applying for disability benefits.

- If your injury is diagnosed as a sprain, strain or a whiplash associated disorder (I or II), this form needs to be submitted within 10 days after the date of the accident so that you can access accident benefits described as the “Diagnostic and Treatment Protocols.”
- If you have other types of injuries or you choose not to access the accident benefits described as the “Diagnostic and Treatment Protocols” then the form should be submitted within 30 days of the accident.

If you are unable to return the form within these time frames, submit it to your insurance company as soon as practicable and explain the reason for the delay.

### **Claim for Disability Benefits (Form AB – 1a)**

If the insurance company asks you to, please fill out the first section (Parts 1, 2 and 3) and give this form to your medical doctor to complete. You may be required to pay the medical doctor for the completion of this form. The insurer is required to reimburse you for this expense.

### **Treatment Plan (Form AB – 2) and Confirmation of Services Provided (Form AB – 2a)**

You and/or your primary health care practitioner(s) may claim for planned or incurred services in relation to your injury. Insurance companies require completed Forms 2 and 2a, signed by you and your practitioner, to process the claim.

---

### **Next Steps:**

Make a copy of the form(s) for your records, if desired, and return the original signed form(s) to the insurance company. After the insurance company reviews your completed form(s), you will be contacted about the benefits you are entitled to receive. If your insurance company needs any additional information in order to process your application, they will contact you.

#### ***Important Notice Concerning Your Personal Information***

The personal information you provide in your Accident Claims Benefit Package (i.e. AB-1, AB-1a, AB-2, AB-2a) is collected under the authority of the Insurance Act, Alberta’s Automobile Insurance Accident Benefits Regulation, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

- Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care.
- Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery progress, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Section 3 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part.

Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

Send this form to the appropriate insurer:

Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Notice of Loss & Proof of Claim Form (Form AB-1)

Use this form for accidents that occur on or after October 1, 2004.

**This part is to be completed by your Insurer**

<b>Claim Number:</b>	
<b>Insurance Company</b>	
<b>Claim Representative</b>	
<b>Policy Number:</b>	
<b>Date of Accident: (DD MM YYYY)</b>	

### Section 1: Claimant Information

(This section is to be completed by the injured person (the claimant) or the claimant's authorized representative (agent))

#### Part 1 Claimant Information

Last Name		First Name		Middle Name(s)	
Address					
City, town or country			Province		Postal Code
Telephone Number (Home) (Include area code)		Telephone Number (Work) (Include area code)		Fax Number (Include area code)	
Date Of Birth (DDMMYYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	You can best be reached: <input type="checkbox"/> By telephone <input type="checkbox"/> By personal visit <input type="checkbox"/> At home <input type="checkbox"/> At work <input type="checkbox"/> Other			
When is the best time to reach you? Day(s) of the week			Time of day: __: __ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
Insurance Company			Policy Number		
Will this be an Alberta Workers' Compensation Board Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are Extended Health Care Benefits Available? (e.g., Blue Cross or similar Employee benefits plans) <input type="checkbox"/> Yes <input type="checkbox"/> No Details:		Have you been diagnosed and treated by another practitioner for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:	
If you are making a claim for disability benefits, please also complete Form AB- 1b.					

#### Part 2 Claimant's Authorized Representative Information

Last Name		First Name		Middle Name(s)	
Address					
City, town or county			Province		Postal Code
Relationship with Claimant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			Relevant Documentation Attached? If no, please authorize your representative by completing part 7 of this form. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Home Telephone Number (Include area code)		Work Telephone Number (Include area code)		Fax Number (Include area code)	

#### Part 3 Claimant's Accident Details

(If more space is required please continue on back side of this page)

You were a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other		
Location of Accident		Province
Time of Accident: ____: ____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Was the Accident Reported to the Police? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Reported: (DDMMYYYY)
Brief description of how the accident occurred and how you were injured		

## Section 2: Summary of Injury, Diagnosis and Treatment

(This section is to be completed by a Primary Health Care Practitioner (Chiropractor, Physical Therapist or Medical Doctor) or by a Dentist)

<b>Part 4</b> <b>Information of Primary Health Care Practitioner or Dentist</b>	Name of Primary Health Care Practitioner or Dentist		Profession		
	Address				
	City, town or county		Province	Postal Code	
	Administrative Contact Name		Facility Name		
	Telephone Number (include area code)		Fax Number (include area code)		

<b>Part 5</b> <b>Injury and Diagnosis</b> (To be completed with reference to the Diagnostic and Treatment Protocols Regulation, if applicable)	Location of Examination: <input type="checkbox"/> Emergency Department <input type="checkbox"/> Primary Health Care Practitioner's Office <input type="checkbox"/>		Date of Examination: (DDMMYYYY)		
	Other (please provide details)				
	<b>History</b> <b>(Please Provide Relevant Details For The Following Questions)</b>				
	Describe the mechanism of injury				
	What are the current symptoms the claimant is experiencing?				
	Please provide relevant details of the claimant's past history, including physical, psychological, emotional, cognitive and social history.				
	Is the claimant employed or engaged in or training activities? <input type="checkbox"/> Full time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Not employed <input type="checkbox"/> Unable to work				
Normal activities of daily living					
Has the Patient/Claimant seen any other Primary Health Care Practitioners or Dentist regarding this injury?					

Which health professionals has the claimant seen in the last five years (Name and Date)?

What medications are being taken presently and for what purposes (please describe)?

List any alerting factors (please describe)

How have the claimant's physical functions been affected by the injury?

**Examination**  
**(Please Provide Details of All Relevant Findings)**

General exam

Neurological exam

Musculoskeletal exam

Pain Assessment and Functional Limitations (e.g., activities of daily living)

Ancillary Investigations	
<p style="text-align: center;"><u>Diagnosis</u></p> <p>Sprain 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>Strain 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>WAD 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/></p> <p>Other</p>	<p style="text-align: center;"><u>ICD-10-CA Injury Code*</u></p>

<p><b>Part 6</b></p> <p><b>Treatment</b></p> <p>(To be completed with reference to the Diagnostic and Treatment Protocols Regulation)</p>	<p>Treatment Provided</p>
<p>Ongoing Treatment to be provided:</p> <p><input type="checkbox"/> I will continue providing treatment and will not submit a Treatment Plan (Form AB-2).</p> <p><input type="checkbox"/> I will continue providing treatment and submit a Treatment Plan (Form AB-2) with this form (AB-1) at this time.</p> <p><input type="checkbox"/> I will refer the claimant to a different Primary Health Care Practitioner and I <u>will not</u> submit a Treatment Plan (Form AB-2).</p> <p style="text-align: center;"> <input type="checkbox"/> Physical Therapist                      <input type="checkbox"/> Chiropractor                      <input type="checkbox"/> Medical Doctor </p> <p>Name: _____ Phone Number: (       )</p>	
<p>Have the claimant and the Primary Health Care Practitioner chosen to follow the <i>Diagnostic and Treatment Protocols Regulation</i>?</p> <p style="text-align: center;"><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p>	
<p>Do you expect the claimant to return to normal &amp; essential activities?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> Unable to determine    <input type="checkbox"/> No    If yes, Date Expected?</p>	

\* ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

**Section 3: Certification and Consent to Share Information**

<p>Part 7</p> <p>Authority to act on Claimant's behalf</p> <p>(This section should be completed only when the claimant chooses not to act on his or her own behalf)</p>	<p>I, _____, hereby authorize _____ to act as my representative concerning the treatment and care of my injury, the submission and ongoing handling of my claim for accident and/or disability income benefits and the collection, use and disclosure of information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of this form.</p> <p>I authorize my primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company, _____ and their agents, to collect relevant information concerning me and my accident from my representative as required. I further authorize primary health care practitioner(s), dentist(s), other health service provider(s) and my insurance company to disclose relevant information concerning my injury, diagnosis, assessment, treatment and care and my claim for accident and/or disability income benefits to my representative.</p> <p>Signature of Claimant _____ Date _____</p> <p>Signature of Authorized Representative _____ Date _____</p>
<p>Part 8</p> <p>Certification and Consent to Share information</p> <p>(To be completed by the Claimant or their authorized representative)</p>	<p>I certify that the information provided is true and correct to the best of my knowledge.</p> <p>I authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service provider(s) to collect, use and disclose any relevant information concerning my injury, including diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 herein, for the purpose of providing ongoing treatment and care.</p> <p>I further authorize all assessing or treating Primary Health Care Practitioners, dentist(s) or other health service providers to disclose my personal information to my insurance company,</p> <p>_____</p> <p>and their agents that is relevant for the purpose of determining my eligibility for accident and disability benefits as outlined on Form AB-1 and for the purpose of administering my claim.</p> <p>I further authorize my insurance company and its agents to collect, use and disclose relevant information concerning my injury, diagnosis, assessment, treatment or care received as a result of the automobile accident referred to in Section 1 herein, including a treatment plan and services provided, for the purpose of determining my eligibility for accident and disability benefits as outline on Form AB-1 and administering my claim.</p> <p><input type="checkbox"/> I am the claimant or <input type="checkbox"/> I am the authorized representative of the claimant</p> <p>Signature _____ Date _____</p>
<p>Part 9</p> <p>Signature of Primary Health Care Practitioner or Dentist</p>	<p>I certify that the information provided is true and correct to the best of my knowledge.</p> <p>Signature _____ Date _____</p>

# Form AB- 1A — Claim for Disability Benefits



<b>Part 3</b> <b>Information of Medical Doctor</b> (To be completed by Medical Doctor)	Name of Professional		Profession
	Address		
	City, town or county	Province	Postal Code
	Administrative Contact Name		Facility Name
	Telephone Number (Include area code)		Fax Number (Include area code)

<b>Part 4</b> <b>Signature of Medical Doctor for Disability Benefits Claim</b>	To the best of my knowledge, the claimant is totally disabled (unable to work) From _____ 20____ to _____ 20____ inclusive. If still disabled give approximate date patient should be able to return to work, _____ 20____.	
	Name (printed) _____  Signature _____ Date _____	

# Form AB-2 — Treatment Plan

Return this form to the appropriate insurer:

Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Treatment Plan (Form AB-2)

Use this form for accidents that occur on or after October 1, 2004.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner

Insurance Company

Policy Number:

Date of Accident:  
(DD MM YYYY)

### Part 1 Claimant Information

Last Name

First Name

Date of Birth (DDMMYYYY)

Date of Accident (DDMMYYYY)

### Part 2 Claimant's Authorized Representative

Last Name

First Name

Middle Name(s)

Address

City, town or county

Province

Postal Code

Relationship with Claimant  Parent  Guardian  Other

Home Telephone Number (Include area code)

Work Telephone Number (Include area code)

Fax Number (Include area code)

### Part 3 Therapy Status Report (to be completed by Primary Health Care Practitioner)

Diagnosis:

Key Subjective/Physical Examination Findings:

Diagnosis

Sprain  
1  2  3

Strain  
1  2  3

WAD  
1  2  3  4

Other

ICD-10-CA Injury Code\*

Is the claimant employed or engaged in training activities?

Full Time  Part Time  Seasonal  Self-employed  Retired  Student  Not employed

\*

ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

Functional Goals (outcomes to be measured):	
1.	
2.	
3.	
Comments	
Expected Number of Visits	Do you expect these visits to be sufficient to meet functional goals? <input type="checkbox"/> Yes <input type="checkbox"/> No   If no, please provide details of expected further assessment and treatment
Do you expect to reassess within three weeks due to alerting factors? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please describe	Date of expected treatment discharge (MMDDYYYY)

<b>Part 4</b> <b>Treatment</b> (To be completed with reference to the Diagnostic and Treatment Protocols Regulation)	Treatment Provided
	Do you expect the claimant to return to normal & essential activities? <input type="checkbox"/> Yes <input type="checkbox"/> Unable to determine <input type="checkbox"/> No   If yes, date expected?

<b>Part 5</b> <b>Primary Health Care Practitioner Information</b>	Name of Primary Health Care Practitioner <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical Therapist		
	Address		
	City, town or county	Province	Postal Code
	Administrative Contact Name	Facility Name	
	Telephone Number (Include area code)	Fax Number (Include area code)	

<b>Part 6</b> <b>Signature of Primary Health Care Practitioner</b>	I certify that the information provided is true and correct to the best of my knowledge.
	Name (Please Print) _____
	Signature _____ Date _____

Part 7  
**Choice in  
Following  
Diagnostic and  
Treatment  
Protocols**

Please state your preference of treatment within or not within the Diagnostic & Treatment Protocols:

I choose to be treated within the Diagnostic & Treatment Protocols as indicated on Form AB-1

I choose not to be treated within the Diagnostic & Treatment Protocols

I am the claimant or  I am the authorized representative of the claimant

I certify that the information provided is true and correct the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outlined on Form AB-1.

Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Form AB-2a — Confirmation of Services Provided



**Part 5  
Claimant  
Confirmation**

I am the claimant or  I am the authorized representative of the claimant

I confirm that I have received the treatment, supplies or services identified on this form or the signed attachments. I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information concerning my injury, diagnosis, assessment, treatment or care resulting from the automobile accident referred to in Section 1 of Form AB-1 and regarding my eligibility for accident benefits as outlined on Form AB-1.

Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Part 6  
Confirmation of  
Adjunct  
Therapy  
Provider**

I confirm that I have provided the treatment, supplies or services identified on this form or have signed the attachments.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Part 7  
Confirmation of  
Primary Health  
Care  
Practitioner**

I confirm that I have provided the treatment, supplies or services identified on this form, or have authorized the adjunct therapy provider for these services or have signed the attachments.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Form AB-3 — Progress Report

Send this form to the appropriate insurer:

Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Progress Report (Form AB-3)

Use this form for accidents that occur on or after October 1, 2004.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner

Insurance Company

Policy Number:

Date of Accident:  
(DD MM YYYY)

<b>Part 1 Claimant Information</b>	Last Name	First Name	Date Of Birth (DDMMYYYY)
	Date of Initial Assessment (DDMMYYYY)		

<b>Part 2 Information of Primary Health Care Practitioner</b>	Name of Professional		Profession	
	Address			
	City, town or county		Province	Postal Code
	Administrative Contact Name		Facility Name	
	Telephone Number (Include area code)		Fax Number (Include area code)	

<b>Part 3 Therapy Status Report</b>	Diagnosis:  Key Subjective and Physical Examination Findings:	
	Functional Goals: 1.  2.  3.	Progress towards goals  <input type="checkbox"/> Regressed <input type="checkbox"/> improved minimally <input type="checkbox"/> Improved significantly <input type="checkbox"/> Resolved <input type="checkbox"/> Plateaued <input type="checkbox"/> Other (please describe)

<b>Part 4 Signature of Primary Health Care Practitioner</b>	Name (Please Print) _____
	Signature _____ Date _____

# Form AB-4 — Concluding Report

Send this form to the appropriate insurer:

Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Concluding Report (Form AB-4)

Use this form for accidents that occur on or after October 1, 2004.

**This part to be completed by the claimant or their representative or a Primary Health Care Practitioner**

Insurance Company	
Policy Number:	
Date of Accident: (DD MM YYYY)	

<b>Part 1 Claimant Information</b>	Last Name	First Name	Date Of Birth (DDMMYYYY)
	Date of Initial Assessment (DDMMYYYY)		

<b>Part 2 Information of Primary Health Care Practitioner</b>	Name of Professional		Profession
	Address		
	City, town or county	Province	Postal Code
	Scheduling Contact Name		Facility Name
	Telephone Number (Include area code)		Fax Number (Include area code)

<b>Part 3 Assessment Status</b>	Diagnosis at initial assessment:	
	Key Subjective and Physical Examination Findings at the last visit:	
	Functional Goals:	Progress towards goals

1.  2.  3.	<input type="checkbox"/> Regressed <input type="checkbox"/> improved minimally <input type="checkbox"/> Improved significantly <input type="checkbox"/> Resolved <input type="checkbox"/> Plateaued <input type="checkbox"/> Other (please describe)
------------------------	---

<b>Part 4 Treatment Summary</b>	Total Number of Treatments	Date of first visit (DDMMYY)	Date of last visit (DDMMYY)	Total cancelled/missed visits

<b>Part 5 Reason for Discharge or need for ongoing Treatment</b>	<input type="checkbox"/> Full Recovery <input type="checkbox"/> Transferred to another treatment site <input type="checkbox"/> Partial Recovery <input type="checkbox"/> Non-attendance <input type="checkbox"/> Plateaued <input type="checkbox"/> Poor Compliance <input type="checkbox"/> No Progress <input type="checkbox"/> No Contact	<input type="checkbox"/> Other (please describe)

<b>Part 6 Discharge Status</b>	Is the claimant now working? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Are they employed or engaged in training activities? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Not employed
	Work or training restrictions: <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> If yes, a temporary restriction <input type="checkbox"/> If yes, a permanent restriction
	Has the claimant returned to a pre-accident level of activity outside work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Did you refer the claimant to any other health care provider(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, who? _____
	Discharge comments (residual symptoms, signs, prognosis, details of exercise program, etc.):

<b>Part 7 Signature of Primary Health Care Practitioner</b>	Name _____
	Signature _____ Date _____

# Form AB-5 — Referral to an Injury Management Consultant

Send this form to the appropriate insurer

Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

and Health Care Practitioner

## Referral Form (Form AB-5)

Use this form for accidents that occur on or after October 1, 2004.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner

Insurance Company	
Policy Number:	
Date of Accident: (DD MM YYYY)	

### Referral to:

- Primary Health Care Practitioner  
 Injury Management Consultant  
 Other \_\_\_\_\_

### Section 1: Claimant Information

Part 1 Claimant Information	Date Of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number		
	Last Name	First Name	Middle Name		
	Address				
	City, town or county		Province	Postal Code	
	Representative (if applicable)	Address			
	Telephone Number (Include area code)	Fax Number (Include area code)			

Part 2 Information of Primary Health Care Practitioner who is Referring the Claimant	Name of Professional		Profession		
	Address				
	City, town or county		Province	Postal Code	
	Administrative Contact Name		Facility Name		
	Telephone Number (Include area code)	Fax Number (Include area code)			

Part 3 Information of Professional to whom Claimant is being Referred	Name of Professional		Profession		
	Address				
	City, town or county		Province	Postal Code	
	Administrative Contact Name		Facility Name		
	Telephone Number (Include area code)	Fax Number (Include area code)			

**Section 2:**

**Summary of Injury and Treatment**  
(To be completed by the Primary Health Care Practitioner)

<p>Part 4 <b>Reason for the referral</b></p>	<p>Opinion requested for:    <input type="checkbox"/> Definitive diagnosis        <input type="checkbox"/> Treatment</p>
--	--

<p>Part 5 <b>Details of the injury investigations and treatment to date</b></p>	
---	--

<p>Part 6 <b>Information Enclosed</b></p>	<p>I am enclosing the following relevant information (e.g., consent form, reports of investigation including laboratory analysis, diagnostic imaging, or other reports):</p>
---	--

<p>Part 7 <b>Signature of Primary Health Care Practitioner</b></p>	<p>Signature _____ Date _____</p>
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## Appendix H — Recommended Guidelines: Injury Management Consultant Report

## Recommended Guidelines – Injury Management Consultant Report

1. Statement of the purpose for the examination and relevant issues
2. Review of relevant information from the primary health care practitioner
3. Relevant history of the injury including:
  - Mechanism of injury
  - Previous history of injury to the same part of the body
  - Progress of recovery that includes review of consultation(s), investigations, and treatment as well as response to treatment.
4. Relevant medical history – physical, psychological, emotional, cognitive, and surgical history.
5. Current status of patient (claimant) including present complaints.
6. Details of examination including:
  - General
  - Regional
  - Musculoskeletal
  - Neurological
  - Any functional limitations
7. Any further investigation and assessment carried out
8. Diagnosis and prognosis
9. Recommended treatment or further assessment.