

APPENDIX

Insurance Act

DIAGNOSTIC AND TREATMENT PROTOCOLS REGULATION

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Definitions

1(1) In this Regulation,

- (a) “client” means an insured person as defined in the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (b) “evidence-based practice” means the conscientious, explicit and judicious use of current best practice in making decisions about the care of a client, integrating individual clinical expertise with the best available external clinical evidence from systematic research;
- (c) “health care practitioner” means
 - (i) a physician,
 - (ii) a registered member as defined in the *Chiropractic Profession Act*, or
 - (iii) a physical therapist as defined in the *Physical Therapy Profession Act*,

- who is entitled to practise their profession in Alberta;
- (d) “IMC register” means the register of injury management consultants established under section 26;
 - (e) “injury management consultant” means a health care practitioner who is entered on the IMC register in accordance with Part 3;
 - (f) “insurer” has the same meaning as it has in the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
 - (g) “International Classification of Diseases” means the most recent edition of the publication titled the *International Statistical Classification of Diseases and Related Health Problems*, Canada, published by the Canadian Institute of Health Information, based on a publication issued from time to time titled the *International Statistical Classification of Diseases and Related Health Problems*, published by the World Health Organization;
 - (h) “prescribed claim form” means the form established by the Minister under section 803 of the *Insurance Act*;
 - (i) “protocols” means the diagnostic and treatment protocols established by this Regulation;
 - (j) “sprain” means an injury to one or more of the tendons or ligaments, or to both;
 - (k) “strain” means an injury to one or more muscles;
 - (l) “Superintendent” means the Superintendent of Insurance appointed under the *Insurance Act*;
 - (m) “WAD injury” means a whiplash associated disorder other than one that exhibits one or both of the following:
 - (i) objective, demonstrable, definable and clinically relevant neurological signs;
 - (ii) a fracture to or a dislocation of the spine.

(2) For the purpose of section 629 of the Act, “assessment” includes diagnosis.

Part 1 Application and Operation

Application of this Regulation

- 2** This Regulation applies only in cases where
- (a) a client wishes to be diagnosed and treated in accordance with the protocols for a sprain, strain or WAD injury caused by an accident arising from the use or operation of an automobile, and
 - (b) a health care practitioner chooses to diagnose and treat the client's sprain, strain or WAD injury in accordance with the protocols.

Authorization for additional services or supplies

3 Nothing in this Regulation prevents or limits a client or a health care practitioner from applying to an insurer for an authorization for a service or supply in addition to the limits specified by this Regulation, and the insurer may, in accordance with the *Automobile Accident Insurance Benefits Regulations (AR 352/72)*, approve the additional service or supply.

Interpretative bulletins and information circulars

- 4** The Superintendent may issue interpretative bulletins and information circulars
- (a) describing the anticipated roles and general expectations of those persons affected by or who have an interest in the implementation, application and administration of the protocols;
 - (b) respecting the administration, implementation and operation of the protocols;
 - (c) respecting any other matter the Superintendent considers appropriate.

Prescribed fees

5(1) The Superintendent may prescribe the fees and disbursements or the maximum fees and disbursements to be paid for any service, diagnostic imaging, laboratory testing, specialized testing, supply, treatment, visit, therapy, assessment or making a report under this Regulation, or any other activity or function necessitated by, described in or referred to in this Regulation.

(2) The fees and disbursements or maximum fees and disbursements prescribed under subsection (1) must be published in The Alberta Gazette.

Part 2 Diagnosis and Treatment Protocols

Division 1 Diagnosis and Treatment Protocol for Strains

Protocols established

6 Sections 7 to 9 are established as protocols for the diagnosis and treatment of strains.

Developing the diagnosis

7(1) With reference to the International Classification of Diseases and using evidence-based practice, a diagnosis of a strain is to be established by a health care practitioner using the following process:

- (a) taking a history of the client, including
 - (i) how the injury occurred,
 - (ii) the current symptoms the client is experiencing,
 - (iii) the client's relevant past history, including physical, psychological, emotional, cognitive and social history, and
 - (iv) how the client's physical functions have been affected by the injury;
- (b) examining the client, including
 - (i) a general examination,
 - (ii) a relevant regional examination, including
 - (A) an examination of the neurological system, and
 - (B) an examination of the musculoskeletal system,and
 - (iii) assessing the pain associated with the injury;
- (c) making an ancillary investigation, including, as required,

- (i) diagnostic imaging,
- (ii) laboratory testing, and
- (iii) specialized testing;
- (d) identifying the muscle or muscle groups injured.

(2) If a strain is diagnosed, the diagnostic criteria to be used to determine the degree of severity of the strain are set out in the following table, extracted from *Orthopaedic Physical Assessment* by David J. Magee, (3rd), (1997), pg 19, with permission from Elsevier Inc.:

	1st degree strain	2nd degree strain	3rd degree strain
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

Treatment protocols

8 A strain is to be treated by

- (a) educating the client with respect to at least the following matters:
 - (i) the desirability of an early return to normal activities and to work, if applicable;
 - (ii) an estimate of the probable length of time that symptoms will last;
- (b) managing inflammation and pain, as required,
 - (i) by the protected use of ice;
 - (ii) by elevating the injured area;
 - (iii) by compression;
- (c) teaching the client about maintaining flexibility, balance, strength and the functions of the injured area;
- (d) giving advice about self-care and the disadvantage of extended dependence on health care providers;
- (e) subject to section 9(3), providing treatment that is appropriate and within the scope of practice of the person providing it under
 - (i) the *Medical Profession Act*,
 - (ii) the *Chiropractic Profession Act*, or
 - (iii) the *Physical Therapy Profession Act*,as the case may be, and that is necessary, in the opinion of the health care practitioner, for the treatment or rehabilitation of the injury;
- (f) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the client.

Diagnostic and treatment authorization

9(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 1st degree strain, a 2nd degree strain or a 3rd degree strain,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication to manage the inflammation or pain, or both;
- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 1st degree strain or a 2nd degree strain, not more than a combined total of 10 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 8.

(3) Under these protocols, a health care practitioner may not use a visit to treat a 1st degree strain or a 2nd degree strain by a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop.

(4) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 3rd degree strain,

- (a) necessary diagnostic imaging, laboratory testing and specialized testing;
- (b) necessary medication;
- (c) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(5) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 3rd degree strain, a combined total of 21 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 8, and in particular definitive care of specific muscles or muscle groups at specific anatomical sites, including, as required,

- (a) immobilization,
- (b) strengthening exercises,
- (c) surgery, and
- (d) if surgery is required, post-operative rehabilitation therapy.

Division 2 Diagnosis and Treatment Protocol for Sprains

Protocols established

10 Sections 11 to 13 are established as protocols for the diagnosis and treatment of sprains.

Developing the diagnosis

11(1) With reference to the International Classification of Diseases and using evidence-based practice, a diagnosis of a sprain is to be established by a health care practitioner using the following process:

- (a) taking a history of the client, including
 - (i) how the injury occurred,
 - (ii) the current symptoms the client is experiencing,
 - (iii) the client's relevant past history, including physical, psychological, emotional, cognitive and social history, and
 - (iv) how the client's physical functions have been affected by the injury;
- (b) examining the client, including
 - (i) a general examination,
 - (ii) a relevant regional examination, including
 - (A) an examination of the neurological system, and
 - (B) an examination of the musculoskeletal system,and
 - (iii) assessing the pain associated with the injury;

- (c) making an ancillary investigation, including, as required,
 - (i) diagnostic imaging,
 - (ii) laboratory testing, and
 - (iii) specialized testing;
- (d) identifying the tendons or ligaments, or both, that are involved and the specific anatomical site of the injury.

(2) If a sprain is diagnosed, the diagnostic criteria to be used to determine the degree of severity of the sprain are set out in the following table, extracted from *Orthopaedic Physical Assessment* by David J. Magee, (3rd), (1997), pg 19, with permission from Elsevier Inc.:

	1st degree sprain	2nd degree sprain	3rd degree sprain
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	Decreased	Decreased	May increase or

	1st degree sprain	2nd degree sprain	3rd degree sprain
Motion			decrease depending on swelling Dislocation or subluxation possible

Treatment protocols

12 A sprain is to be treated by

- (a) educating the client with respect to at least the following matters:
 - (i) the desirability of an early return to normal activities and to work, if applicable;
 - (ii) an estimate of the probable length of time that symptoms will last;
- (b) managing inflammation and pain, as required,
 - (i) by the protected use of ice;
 - (ii) by elevating the injured area;
 - (iii) by compression;
- (c) teaching the client about maintaining flexibility, balance, strength and the functions of the injured area;
- (d) giving advice about self-care and the disadvantage of extended dependence on health care providers;
- (e) subject to section 13(3), providing treatment that is appropriate and within the scope of practice of the person providing it under
 - (i) the *Medical Profession Act*,
 - (ii) the *Chiropractic Profession Act*, or
 - (iii) the *Physical Therapy Profession Act*,

as the case may be, and that is necessary, in the opinion of the health care practitioner, for the treatment or rehabilitation of the injury;

- (f) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the client.

Diagnostic and treatment authorization

13(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 1st degree sprain, a 2nd degree sprain or a 3rd degree sprain,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication to manage the inflammation or pain, or both;
- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 1st degree sprain or a 2nd degree, sprain not more than a combined total of 10 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 12.

(3) Under these protocols, a health care practitioner may not use a visit to treat a 1st degree sprain or a 2nd degree sprain by a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop.

(4) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 3rd degree sprain,

- (a) necessary diagnostic imaging, laboratory testing and specialized testing;
- (b) necessary medication;

- (c) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(5) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 3rd degree sprain, a combined total of 21 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 12, and in particular definitive care of specific tendons or ligaments at specific anatomical sites, including, as required,

- (a) immobilization,
- (b) strengthening exercises,
- (c) surgery, and
- (d) if surgery is required, post-operative rehabilitation therapy.

Division 3 Diagnostic and Treatment Protocol for WAD Injuries

Protocols established

14 Sections 15 to 21 are established as protocols for the diagnosis and treatment of WAD injuries.

Developing the diagnosis

15 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 using evidence-based practice, a diagnosis of a WAD injury is to be established by a health care practitioner using the following process:

- (a) taking a history of the client, including
 - (i) how the injury occurred,
 - (ii) the current symptoms the client is experiencing,
 - (iii) the client's relevant past history, including physical, psychological, emotional, cognitive and social history,

- (iv) inquiry into alerting factors that may influence prognosis, and
- (v) how the client's physical functions have been affected by the injury;
- (b) examining the client, including
 - (i) a general examination,
 - (ii) a relevant regional examination, including
 - (A) an examination of the neurological system, and
 - (B) an examination of the musculoskeletal system,
 - and
 - (iii) assessing the pain associated with the injury;
- (c) making an ancillary investigation, including, as required,
 - (i) diagnostic imaging,
 - (ii) laboratory testing, and
 - (iii) specialized testing;
- (d) identifying the anatomical sites.

Diagnostic Criteria and Treatment of WAD I Injuries

Diagnostic criteria: WAD I injuries

16(1) If a WAD injury is diagnosed, the criteria to be used to diagnose a WAD I injury are

- (a) complaints of spinal pain, stiffness or tenderness;
- (b) no demonstrable, definable and clinically relevant physical signs of injury;
- (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- (d) no fractures to or dislocation of the spine.

(2) If a WAD I injury is diagnosed, no further investigation of the injury is warranted, unless there is cause to do so.

Treatment protocols: WAD I injuries

- 17** A WAD I injury is to be treated, as required, by
- (a) educating the client with respect to at least the following matters:
 - (i) the desirability of an early return to normal activities and to work, if applicable;
 - (ii) an estimate of the probable length of time that symptoms will last;
 - (iii) reassurance that there is likely no serious currently detectable underlying cause of the pain;
 - (iv) the importance of postural and body mechanics control;
 - (v) that the use of a soft collar is not advised;
 - (vi) the probable factors that are responsible for other symptoms the client may be experiencing that are temporary in nature and that are not reflective of tissue damage, including
 - (A) disturbance of balance,
 - (B) disturbance or loss of hearing,
 - (C) limb pain or numbness,
 - (D) cognitive dysfunction, and
 - (E) jaw pain;
 - (b) giving advice about self-care and the disadvantage of extended dependence on health care providers;
 - (c) prescribing medication, including the appropriate use of analgesics, which may include short-term use of non-opioid analgesics or non-steroidal anti-inflammatory drugs, but muscle relaxants and narcotics are not authorized under these protocols for treatment of WAD I injuries;
 - (d) in the case of treatment of an injury,
 - (i) pain management, as required;

- (ii) injury specific exercises;
 - (iii) early return to normal activities;
 - (iv) a home exercise program to improve range of motion;
 - (v) thermal therapy by the client;
 - (vi) preparing the client for a return to work, if appropriate;
- (e) providing treatment that is appropriate and within the scope of practice of the person providing it under
- (i) the *Medical Profession Act*,
 - (ii) the *Chiropractic Profession Act*, or
 - (iii) the *Physical Therapy Profession Act*,
- as the case may be, and that is necessary, in the opinion of the health care practitioner, for the treatment or rehabilitation of the injury;
- (f) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the client.

Diagnostic and treatment authorization

18(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a WAD I injury,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication to manage the inflammation or pain, or both;

- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a WAD I injury, not more than a combined total of 10 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 17.

Diagnostic Criteria and Treatment of WAD II Injuries

Diagnostic criteria: WAD II injuries

19(1) If a WAD injury is diagnosed, the criteria to be used to diagnose a WAD II injury are

- (a) complaints of spinal pain, stiffness or tenderness;
- (b) demonstrable, definable and clinically relevant physical signs of injury, including
 - (i) musculoskeletal signs of decreased range of motion of the spine, and
 - (ii) point tenderness of spinal structures affected by the injury;
- (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- (d) no fracture to or dislocation of the spine.

(2) An investigation to determine a WAD II injury and to rule out a more severe whiplash injury may include

- (a) for cervical spine injuries, radiographic series in accordance with *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;
- (b) for thoracic, lumbar and lumbosacral spine injuries, radiographic series appropriate to the region of the spine that is injured, if the client has one or more of the following characteristics:

- (i) an indication of bone injury;
- (ii) an indication of significant degenerative changes or instability;
- (iii) an indication of rheumatoid arthritis;
- (iv) an indication of osteoporosis;
- (v) a history of cancer.

(3) The use of magnetic resonance imaging or computerized tomography is not authorized under these protocols, unless 3 plain view films are equivocal.

Treatment protocols: WAD II injuries

20 A WAD II injury is to be treated, as required, by

- (a) educating the client with respect to at least the following matters:
 - (i) the desirability of an early return to normal activities and to work, if applicable;
 - (ii) an estimate of the probable length of time that symptoms will last;
 - (iii) reassurance that there is likely no serious currently detectable underlying cause of the pain;
 - (iv) the importance of postural and body mechanics control;
 - (v) that the use of a soft collar is not advised;
 - (vi) the probable factors that are responsible for other symptoms the client may be experiencing that are temporary in nature and that are not reflective of tissue damage, including
 - (A) disturbance of balance,
 - (B) disturbance or loss of hearing,
 - (C) limb pain or numbness,
 - (D) cognitive dysfunction, and

- (E) jaw pain;
- (b) giving advice about self-care and the disadvantage of extended dependence on health care providers;
- (c) prescribing medication, including the appropriate use of analgesics, which may include short-term use of non-opioid analgesics or non-steroidal anti-inflammatory drugs, but muscle relaxants and narcotics are not authorized under these protocols for treatment of WAD II injuries;
- (d) in the case of treatment of an injury,
 - (i) pain management, as required;
 - (ii) injury specific exercises;
 - (iii) early return to normal activities;
 - (iv) a home exercise program to improve range of motion;
 - (v) initiation of manipulation, manual therapy or mobilization, or any 2 or more of them, to improve function, if appropriate;
 - (vi) preparing the client for a return to work, if appropriate;
- (e) providing treatment that is appropriate and within the scope of practice of the person providing it under
 - (i) the *Medical Profession Act*,
 - (ii) the *Chiropractic Profession Act*, or
 - (iii) the *Physical Therapy Profession Act*,as the case may be, and that is necessary, in the opinion of the health care practitioner, for the treatment or rehabilitation of the injury;
- (f) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the client.

Diagnostic and treatment authorization

21(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a WAD II injury,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication to manage the inflammation or pain, or both;
- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 22, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a WAD II injury, not more than a combined total of 21 medical, physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 20.

**Division 4
Treatment Limits and Referrals**

Aggregate limits on visits

22(1) Except as otherwise specifically provided in this Regulation, if a client is diagnosed and treated under these protocols for 2 or more injuries,

- (a) only one visit for an assessment of the injuries by a health care practitioner is authorized by these protocols;
- (b) if the injuries are diagnosed as a 1st degree strain, 2nd degree strain, 1st degree sprain or 2nd degree sprain, the cumulative total of visits for the 2 or more injuries that may be authorized under the protocols, without the approval of the insurer, may not exceed 10;
- (c) if 2 or more of the injuries described in clause (b) and one or more of

- (i) a 3rd degree strain for which treatment is authorized,
- (ii) a 3rd degree sprain for which treatment is authorized,
or
- (iii) a WAD II injury

are diagnosed, the cumulative total of visits for the 2 or more injuries that may be authorized under the protocols, without the approval of the insurer, may not exceed 21;

- (d) if 2 or more of
 - (i) a 3rd degree strain,
 - (ii) a 3rd degree sprain, or
 - (iii) a WAD II injury

are diagnosed, the cumulative total of visits for the 2 or more injuries that may be authorized under these protocols, without the approval of the insurer, may not exceed 21.

(2) Despite anything in this Regulation,

- (a) an authorization by a health care practitioner for anything permitted by these protocols must be in writing and issued within 90 days of the date of the accident in which the client was injured,
- (b) an authorization under these protocols expires 90 days after the date of the accident in which the client was injured, unless the authorization is approved by an insurer for use after the 90 days, and
- (c) an authorization may be issued in respect of the person who issues the authorization.

Assessment of non-protocol injuries

23 If, after an assessment, a physical therapist as defined in the *Physical Therapy Act* or a registered member as defined in the *Chiropractic Profession Act* diagnoses an injury as one to which these protocols do not apply, these protocols authorize a claim under Part 3 for the assessment.

Referral to injury management consultant

24(1) A health care practitioner may authorize a visit by a client to an injury management consultant if the health care practitioner

- (a) is uncertain about an injury to which the protocols apply or the diagnosis or treatment of it;
- (b) believes that the injury
 - (i) is not resolving appropriately, or
 - (ii) is not resolving within the time expected and the practitioner requires another opinion or report.

(2) If a client is diagnosed with a WAD I or WAD II injury and the client has any alerting factor that may influence prognosis, the health care practitioner must seek to reassess the client within 21 days of the accident and, if the injury is not resolving, authorize a visit by the client to an injury management consultant for an assessment and report.

(3) The visit and the cost and expenses related to an assessment and report by an injury management consultant under subsection (2) are authorized to be claimed under Part 3 and are in addition to the aggregate limit on visits referred to in section 22.

(4) Except for the visit, assessment and report described in this section, no further visit, assessment or report by an injury management consultant in respect of the same injury is authorized by these protocols, unless the insurer approves of it.

Injuries unresolved after 90 days

25(1) Subject to subsection (3), if after 90 days from the date of the accident an injury has not resolved or is not satisfactorily resolving, the health care practitioner may refer the client to an injury management consultant.

(2) The injury management consultant may

- (a) provide advice and a report about the diagnosis or treatment of the client, or
- (b) 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.

(3) No examination, further assessment, multi-disciplinary assessment or any report referred to in subsection (2), and no visit or treatment as a result, is authorized by these protocols, unless the insurer approves it.

Part 3 Injury Management Consultants Register

Register established

26(1) The Superintendent must establish, maintain and administer a register of injury management consultants.

(2) The Superintendent must ensure that the IMC register is published in a form and manner so that the register is accessible to the public.

Eligibility requirements

27(1) A health care practitioner is an injury management consultant under this Regulation if, in accordance with this Part,

- (a) the council of the College of Physicians and Surgeons of the Province of Alberta notifies the Superintendent that a physician meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register;
- (b) the Council of the College of Chiropractors of Alberta notifies the Superintendent that a registered member as defined in the *Chiropractic Profession Act* meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register;
- (c) the Council of the College of Physical Therapists of Alberta notifies the Superintendent that a physical therapist as defined in the *Physical Therapy Profession Act* meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register.

(2) A person is eligible to be an injury management consultant if the person

- (a) is an active practising member of that person's profession,

- (b) has demonstrated to the satisfaction of the council of that person's profession that he or she
 - (i) is knowledgeable with respect to the biopsychosocial model,
 - (ii) is knowledgeable with respect to assessing acute and chronic pain,
 - (iii) is experienced in rehabilitation and disability management, and
 - (iv) uses evidence-based decision-making in his or her practice,

and

- (c) meets any additional qualifications established by the Superintendent and approved by the councils of the colleges concerned.

Ceasing to be an injury management consultant

- 28** A person ceases to be an injury management consultant if
- (a) the council of the profession concerned notifies the Superintendent that the person's name is to be removed from the IMC register, and
 - (b) the Superintendent removes the person's name from the IMC register.

Transitional

29(1) Notwithstanding section 27, the Superintendent may enter on the IMC register the name of a physician, a registered member as defined in the *Chiropractic Profession Act* or a physical therapist as defined in the *Physical Therapy Profession Act* when the respective council of the profession concerned notifies the Superintendent that the person

- (a) is an active practising member of the profession, and
- (b) in the opinion of the council, is able to perform the functions of an injury management consultant.

(2) A person whose name is entered on the IMC register under subsection (1) ceases to be an injury management consultant

- (a) on the date the practising member becomes an injury management consultant under section 27,
- (b) 2 years from the date this section comes into force or such later date as the Superintendent determines, or
- (c) on the date the member ceases to be an injury management consultant under section 28,

whichever occurs first.

Part 4 Claims and Payment of Claims

Definitions

30 In this Part,

- (a) “applicant” means a client or health care practitioner who sends a completed prescribed claim form to the insurer under section 32;
- (b) “business days” means any day other than a Saturday, Sunday or other holiday as defined in section 28(1)(x) of the *Interpretation Act*;
- (c) “prescribed claim form” means the form established by the Minister under section 803 of the *Insurance Act*.

Priority of this Part

31 If there is any inconsistency or conflict between this Part and Section B - Accident Benefits under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72), this Part prevails.

Claims

32 A client or health care practitioner who wishes to make a claim under this Part must send to the insurer a completed prescribed claim form, which must include

- (a) details of the injury, and
- (b) details of the accident that are within the personal knowledge of the client,

within 10 business days of the date of an accident or, if that is not reasonable, as soon as practicable after that.

Decision by insurer

33(1) An insurer, within 5 business days of receiving a completed prescribed claim form, must send to the applicant a decision notice

- (a) approving the claim, or
- (b) refusing the claim.

(2) A claim may only be refused by the insurer giving reasons for refusing the claim, but those reasons are limited to the following:

- (a) the person who suffered the injury is not an insured person under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (b) the insurer is not liable to pay as a result of an exclusion contained in the Special Provisions, Definitions and Exclusions of Section B under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (c) there is no contract of insurance in existence that applies with respect to the person who suffered the injury;
- (d) the injury was not caused as a result of an accident arising out of the use or operation of an automobile.

Failure of insurer to respond

34 If an insurer does not send a decision notice back to the applicant within 5 business days of receipt of the applicant's completed prescribed claim form, the insurer

- (a) is deemed to have approved the claim, and
- (b) is liable to pay the claim under section 36, unless the claim is denied under section 35.

Subsequent denial of liability

35(1) If an insurer

- (a) approves a claim, or
- (b) is deemed to have approved a claim

under this Part, the insurer may subsequently deny liability in accordance with subsection (2).

(2) Liability may only be denied if an insurer sends notice in writing to the client and every person whom, under the prescribed claim form, the insurer is notified the client is authorized to visit, or who is authorized to provide services or supplies to the client, giving reasons why liability is denied, but those reasons are limited to the following:

- (a) the person who suffered the injury is not an insured person under the *Automobile Accident Insurance Benefits Regulations*;
- (b) the insurer is not liable to pay as a result of an exclusion contained in the Special Provisions, Definitions and Exclusions of Section B under the *Automobile Accident Insurance Benefits Regulations*;
- (c) there is no contract of insurance in existence that applies with respect to the person who suffered the injury;
- (d) the injury was not caused as a result of an accident arising out of the use or operation of an automobile.

(3) A valid notice of denial under subsection (2) takes effect on the date it is received by the person to whom it is sent and, after receipt of the notice of denial by the client, the insurer is not liable, under section 36, to pay any future claim by a person under this Part.

Making and paying claims

36(1) Where anything is authorized under this Regulation, the authorization may be the subject of a claim under subsection (2).

(2) The insurer must pay a claim that is authorized by this Regulation or is authorized by a health care practitioner or injury management consultant under this Regulation, that,

- (a) in the case of an invoice by a health care practitioner, injury management consultant or provider of an adjunct therapy, is also verified by the client concerned, or
- (b) in the case of a claim by the client, a receipt for the benefit is provided, together with satisfactory evidence that the claim is authorized by this Regulation or is authorized by a health care practitioner under this Regulation.

Sending notices

37 Where this Part requires or permits a notice to be sent to a person, it may be

- (a) delivered personally,
- (b) mailed,
- (c) faxed, or
- (d) transmitted by e-mail if both parties have agreed to this method of sending and receiving notices.

Multiple claims

38 If a person has a claim under these protocols and a claim for other benefits under provisions of Section B of the *Automobile Accident Insurance Benefits Regulations* (AR 352/72), the claimant must comply with this Regulation and the provisions of Section B, according to the claim or claims made.

**Part 5
Review and Coming into Force**

Review

39 This Regulation must be reviewed

- (a) not less than every 2 years from the date this Regulation comes into force, and
- (b) whenever
 - (i) the council of the College of Physicians and Surgeons of the Province of Alberta,
 - (ii) the Council of the College of Chiropractors of Alberta, or
 - (iii) the Council of the College of Physical Therapists of Alberta

provides written notice to the Superintendent that the protocols should be reviewed.

Coming into Force

40 This Regulation comes into force on October 1, 2004.