Auto Insurance Update (02/05)
From the Office of the Alberta Superintendent of Insurance

1. Diagnosis and Treatment Protocol Forms

Form	Notes & Changes to note
AB-1 Notice of loss and proof of claim	• Sections 1 & 3 must be filled out by the patient or his or her designate within 10 days of accident or as soon as practicable. • Practitioners should **not** complete or submit the AB-1 form. There is no fee for completing this form. • The patient or designate can obtain the form from the insurer.
AB-1a Claim for disability benefits	• To be filled out if there is a disability where the patient has a loss of income. • This form is to be completed **only** by physicians, at the request of the insurer. • Physicians can claim the fee for completing this form directly from the patient or his or her insurer. • The patient or designate can obtain form from the insurer.
AB-2 Treatment Plan **(See Notes for MT's)**	• To be filled out by the Primary Health Care Provider: Medical Doctor, Physical therapist or Chiropractor. • **Updated**: to be completed by the PHCP who will be providing the "hands on" treatment visits. In most cases, this will be a physical therapist or a chiropractor. • The form shall be completed within 10 days of the first visit or soon as practicable. • The form shall be sent directly to the insurer for payment. • The patient, or designate, can obtain the form from his or her insurer, or government website: http://www.finance.gov.ab.ca/publications/insurance • The insurer is not obligated to pay for the form until it has been fully and correctly completed. • Whoever submits the form first is the PHCP and dictates treatment within medical protocols.

AB-2a Confirmation of service provided	▪ **Update:** This form is no longer **required.** Optional for MT's. • To be filled out by the service providers outlined in the treatment plan (AB-2 form) Physical therapists, Chiropractors, massage therapists, acupuncturist. • This form is to provide confirmation that the PHCP has approved treatment and therapists will be paid. Insurance companies can refuse payment if there is no signature on the AB-2A form. • This form is to provide verification from the client that treatment was received to avoid any disputes.
AB-3 Progress report	• This form shall be completed only at the request of the insurer and not at the request of the patient. • The form will be sent by the insurer to the PHCP. • The PHCP shall bill the insurer directly.
AB-4 Concluding report	• This form should be completed by the PHCP who provided treatment and completed AB-2 (treatment plan) or has completed the majority of treatment visits. • It shall be completed at the conclusion of treatment visits or once the 90 days are completed. • This form is mandatory for all cases being treated under the Diagnostic and Treatment Protocols Regulation, when an AB-2 form has been completed. • The form can be obtained by the patient or designate form their insurer, or the government website: http://www.finance.gov.ab.ca/publications/insurance • The PHCP shall send this form to the insurer with the last invoice for treatments authorized by the protocols. • A copy of the invoice shall be sent to the patient with an information letter (see general comments) • The insurer is not obligated to pay for the form until it has been full and correctly completed.
AB-5 Referral to an Injury Management Consultant	• Referral to an Injury Management Consultant This form must be completed by the primary health care practitioner who is requesting a consultation. • The primary health care practitioner requesting the referral shall

	notify the insurer of the intent to refer. • The form is available from the insurer or the government website, http://www.finance.gov.ab.ca/publications/insurance • The primary health care practitioner shall bill the insurer directly. • The insurer is not obliged to pay for the form until it has been fully and correctly completed. The PHCP shall bill the insurer directly. • The insurer is not obligated to pay for the form until it has been fully and correctly completed.

Alert

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

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

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

Where a patient chooses to engage another primary health care practitioner after the initial assessment and completion of the AB-2 form, the "new" primary health care practitioner shall bill the patient directly for their assessment and completion of the AB-2 form and this amount is **not recoverable** from the insurer under Section B.

2. Injury Management Consultant (IMC)

Clarifying the purpose

The purpose of a referral to an Injury Management Consultant (IMC) is twofold:
- To establish or confirm a diagnosis and/or
- To provide recommendations on the best treatment options to facilitate recovery.

The purpose of a referral to an Injury Management Consultant is not to gain approval for additional treatment visits beyond the 10 or 21 treatments based on the type of injury. If additional treatment visits are required beyond the 10 or 21 treatments based on the type of injury, the primary health care practitioner shall contact the insurer.

Timing

Referrals to an Injury Management Consultant are made by the primary health care practitioners, not the insurer, prior to 10 or 21 treatments based on the type of injury being concluded and within 90 days of the Motor Vehicle Accident. At any time after 10 or 21 treatment visits based on a type of injury are exhausted or 90 days has lapsed since the accident, insurer authorization is required for an IMC referral.

Advising insurers

When a primary health care practitioner is considering a referral to an Injury Management Consultant, the practitioner is recommended to consult with the insurer. If a referral by the primary health care practitioner is requested, a copy of the completed form AB-5 shall be provided to the insurer.

Injury Management Consultant reports

Injury Management Consultant reports shall be completed and returned to the primary health care practitioner within 10 days of the assessment by the Injury Management Consultant. Acopy shall be provided to the insurer. The report shall contain the following information:
- Patient name and claim number
- Name of referring primary health care practitioner and reason for the referral
- Summary of the history and examination of the patient
- Diagnosis and specific recommendations for managing the injury

Fees

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

Conflict of interest

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

3. Differences in diagnosis

When primary health care practitioners have different opinions on the diagnosis of a patient, the primary health care practitioner who completed the AB-2 form (the treatment plan) will establish the working diagnosis. Primary health care practitioners are expected to discuss and resolve their differences. However, if this is not possible, referral to an Injury Management Consultant will be considered. An insurer does not have the right to choose a preferred diagnosis.

4. Whiplash Associated Disorder (WAD)

The Diagnostic and Treatment Protocols currently include injuries to the entire spine within the WAD category. Following advice from the professions the consensus opinion is that, **WAD injuries include only injuries to the cervical spine**. Strain and sprain injuries to other areas of the spine will not be categorized as WAD injuries. Regulatory changes are under consideration to support this opinion.

The primary health care practitioners must satisfy the referenced criteria to make the diagnosis of WAD injuries.

WAD I criteria:

- symptoms of cervical 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 cervical spine

WAD II criteria:

- symptoms of cervical 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 cervical spine

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

WAD IV criteria:
- fracture to or dislocation of the cervical 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. Number of treatment visits

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

If a primary health care practitioner indicates on the AB-2 form that the patient can be treated with fewer visits, that does not prevent the patient from receiving the full 10 or 21 treatments based on the type of injury **when required**.

Physician visits are covered by Alberta Health Care Insurance and are not included in:
• the 10 or 21 treatments based on the type of injury, or
• the number of assessments available to the patient.

6. General Issues

• Payment for services provided under the DTPby insurers will be within 30 days of receipt of the invoice.

• Payment for a report may not be honored if documents are incomplete or illegible.

• Practitioners are responsible to have an internal administrative process to verify the services provided to patients.

• When generating the final invoice to the insurer, a copy of the invoice shall be mailed to the patient with a standard letter that indicates the following: " your insurer has been billed in the amounts shown for all goods and services listed. Please review the invoice and report any errors to the signatory or your insurer."

• If a patient 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 primary health care practitioner may charge the patient a late or missed appointment fee.

• The Diagnostic and Treatment Protocols Regulationis intended to cover services provided by primary health care practitioner(s) (defined as physicians, physical therapists and chiropractors) and adjunct therapy practitioners (massage therapists and acupuncturists). The provision of other services listed under, Section B, theAutomobile Accident Insurance Benefits Regulation (such as dental services, psychological services, occupational therapy, etc.) to the patient is permitted to occur simultaneously. The provision of these services does not cancel preauthorization of services under the protocols by primary health care practitioners and adjunct therapy providers.

• Adjunct therapies will only be preauthorized when directed by the primary health care practitioners and this is documented on the Treatment Plan form (AB-2). Where adjunct therapies have not be preauthorized, does not prevent patients from obtaining those services under the Section B rules.

• If you are having trouble locating or contacting the claims adjuster for your patient please contact the Insurance Bureau of Canada by phone 1-800-377-6378 or through the website http://ibc.ca. Click "Alberta" on the left hand side column then click "Contact list for health practitioners".

• Further information related to the establishment of fees, form amendments and related issues shall be forwarded to your respective professional associations and published in an interpretive bulletin at http://www.finance.gov.ab.ca/publications/insurance

Notes for Massage Therapists

1. New Section B System

This system only applies to Sprian, Strains, and whiplash injuries. All other injuries fall outside of the new medical protocols. The system has changed again as of February 2005. Massage therapists are to receive a fax or photocopy of the AB-2 form. This will indicate what the PHCP has diagnosed and the treatment protocol prescribed for the client. (This is compliant with the release of personal information act as long at the PHCP has discussed with the client about the use of massage as part of their treatment. It is up to both the sender of the fax and the recipient of the fax to confirm that a clients AB-2 form has been sent and received at the proper location – Due diligence.) No prescription is required.

1st or 2nd degree sprains, strains, or whiplash associated disorders (WAD) I injuries:

- 10 combined treatments are the medical protocol.

3rd degree sprains, strains, or WAD II & WAD III injuries

- 21 combined treatments are the medical protocol.

An initial assessment is permitted for Physical Therapists and Chiropractors which is covered by the insurance companies, but not massage therapists or acupuncturists.
An initial assessment by a Medical Doctor is covered by AHC. (See 5. Number of treatment visits)

Notes:

1. AB-2 form is currently in draft. Changes are being made to include number of treatments specified for each modality, including adjunct therapies.

2. Client can change their PHCP even if they have signed the AB-2 form and have or have not begun treatment. However, they must pay for their second AB-2 form to be filled out. If the client is not at fault in the MVA, they can get reimbursed by suing the third party for collection of cost. The new PHCP will continue where the old PHCP left off.

2. Old Section B System

Once the 10 or 21 treatments, or 90 days are completed, the old section B system applies with a few alterations:

> First, the client must use any work insurance that they might have and provide a statement when their work insurance is exhausted to their car insurance company. A doctors prescription may be required to access benefits. Direct billing is generally not accepted. Check with each insurer before doing any direct billing services.

Then the following coverage is **pre-approved** but **direct billing does not automatically apply.** Direct billing is decided by each insurance company individually. A medical doctors note or prescription is not required to access massage coverage. This is the exchange for the cap of $250.00.

Psychological services $600.00 per person
Chiropractic services $750.00 per person
Physical therapy $600.00 per person
Occupational therapy $600.00 per person
Massage $250.00 per person
Acupuncture $250.00 per person
Grief counseling $400.00 per family

NOTE: there is a soft cap for physiotherapy, occupational therapy and psychology up to a maximum of $50,000.00 if further treatment is approved by the insurance company.

Once the $250.00 is exhausted, the patient can pay and get reimbursed under Section A – economic losses: for medical rehabilitation expenses. Insurance companies **can** work with patient outside of lawyers on this settlement.

3. Which coverage can be used at which time during rehabilitation?

There are three different senario's of treatment that can occur.

1. Massage can be a part of or the complete treatment for the 10 or 21 treatments approved. This will be indicated on the AB-2 form.

2. Once the 10 or 21 treatments are completed, then the client must use their extended health care benefits for massage if they have coverage. Once this is exhausted, then the client can access the $250.00 coverage from their car insurance.

3. If massage was not included in the 10 or 21 treatment plan from the AB-2 form, the client must use any extended health care benefits from their work insurance if there is any coverage. This can be used at the same time as the 10 or 21 treatments are occurring. Once the extended health care benefits are exhausted or if there is no work insurance, the client can access the $250.00 car insurance coverage while the 10 or 21 treatments are in progress. Also note that the $250.00 can be accessed even if the PHCP is unaware or disapproves of massage treatment during the initial 90 days after the MVA.

4.Who can I contact if the patient has been prescribed massage treatment by their physician or PHCP and the insurance company has denied coverage?