Information Bulletin (02/05)

Auto Insurance Update

from the Office of the Alberta Superintendent of Insurance

effective March 16, 2005

1. Diagnosis and Treatment Protocol Forms

Form	Changes to note
AB-1 Notice of loss and proof of claim	• Practitioners should **not** complete or submit the AB-1 form. There is no fee for completing this form. • The form should be completed by the patient or, if required, by his or her designate. • The patient or his or her designate can obtain the form from the insurer.
AB-1a Claim for disability benefits	• This form is to be completed **only** by physicians, at the request of the insurer. • Physicians can claim the fee for completing this form directly from the patient or his or her insurer. • The patient or his or her designate can obtain the form from the insurer.
AB-2 Treatment Plan	• This form is to be completed by the primary health care practitioner 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 his or her designate, can obtain the form from his or her insurer, or the government website, http://www.finance.gov.ab.ca/publications/insurance • The insurer is not obliged to pay for the form until it has been fully and correctly completed.
AB-2a Confirmation of services provided	• This form is no longer required.
AB-3 Progress report	• This form shall be completed **only** at the request of the insurer and **not** at the request of the patient. • The form will be sent by the insurer to the primary health care practitioner. • The primary health care practitioner shall bill the insurer directly.

AB-4 Concluding report	• This form should be completed by the primary health care practitioner who provided treatment and completed form AB-2 (treatment plan) or has completed the majority of treatment visits. • It shall be completed at the conclusion of treatment visits. • The 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 his or her designate from his or her insurer, or the government website, http://www.finance.gov.ab.ca/publications/insurance. • The primary health care practitioner 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 obliged to pay for the form until it has been fully and correctly completed.
AB-5 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.

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.

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

Where a primary health care practitioner has taken 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. A copy shall be provided to the insurer. The report shall contain the following information:

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

Fees

The fee for an Injury Management Consultant's 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 DTP by 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 Regulation* is 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, the *Automobile Accident Insurance Benefits Regulation* (such as dental services, psychological services, occupational therapy, etc.) to the patient is permitted to occur simultaneously. The provision of these services does not cancel preauthorization of services under the 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

These Information Bulletins are provided under the authority of the Insurance Act and relevant regulations. They provide the latest information on changes to the process and requirements for diagnosing, treating, and making claims under the new auto insurance regulations. This information is subject to change and if there is any inconsistency between this interpretive bulletin and the *Insurance Act, Diagnostic and Treatment Protocols Regulation and the Automobile Accident Insurance Benefits Regulation*, the latter Act and Regulations prevails.

Information Bulletins and additional information about auto insurance changes are available online at www.finance.gov.ab.ca/publications/insurance.

If you have questions about the changes noted in this Information Bulletin, please contact:

Dr. Larry Ohlhauser
Senior Medical Advisor to the Superintendent of Insurance
Larry.ohlhauser@gov.ab.ca

If your patients have questions or concerns they are to be directed to their claims adjuster. If they require further information, they may contact the office of the Superintendent of Insurance by e-mail: insurance@gov.ab.ca or by phone: (780) 427-8322. If calling from outside of Edmonton, call 310-0000 and ask to be connected to 780-427-8322.